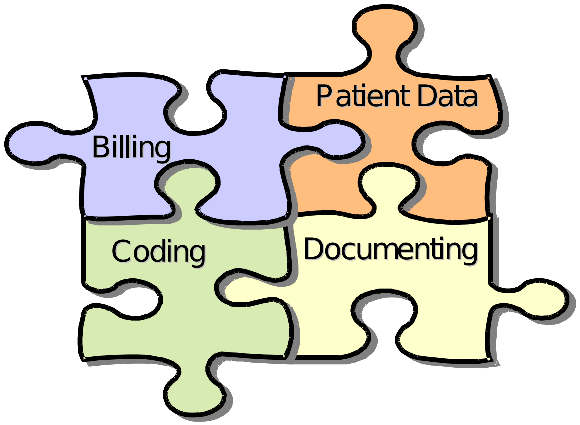
CORE COMPETENCIES

2005 UBU/UBO Conference UBU Advanced (Track 2)

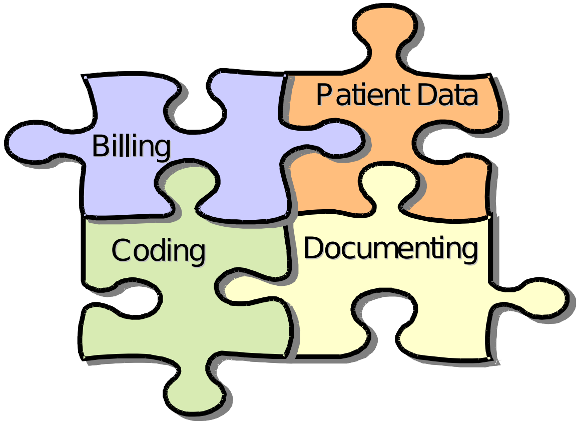
Wednesday - May 18



Contents:

1. Data Quality Management (Milster, MSgt JoAnn)
2. Industry Based Workload Alignment (IBWA) – Update (James, Ron)
3. Low Hanging Fruit (Milster, MSgt JoAnn)
4. GME and the Military Health System (Millican, Lesvia)
5. How Others Use Your Data Understanding Your Customers and Their Needs (Yoder, Lt Col Jeanne)
6. Data Quality Panel (Milster, Cunningham, Bacon – this was a discussion group. No prepared presentation)

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

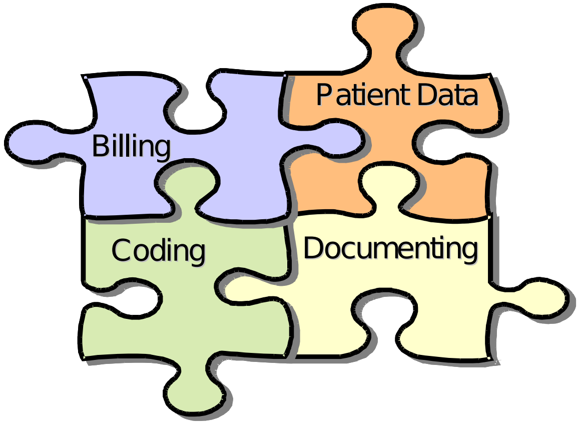
Data Quality Management

MSgt JoAnn Milster
Air Force Data Quality Manager
aka Green Eyeshade Monster

18 May 2005
Track 2

CORE COMPETENCIES

What is Data Quality?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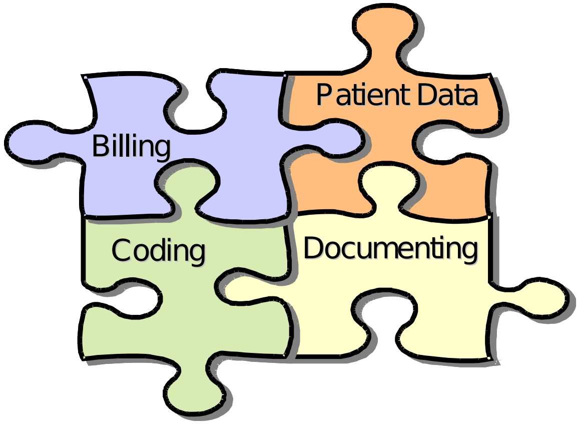
- Is the accurate reflection of the work performed in the MTF that can be used to make informed leadership/management decisions at all levels of command.

It is the view of your MTF from the "Ivory tower"

CORE COMPETENCIES

Military Health System Mission!


Patient Data
Billing
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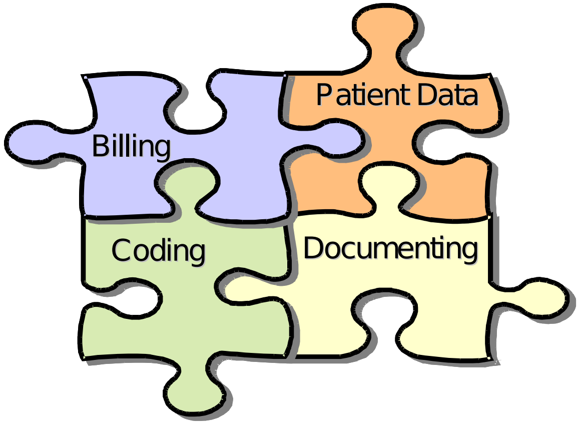
Documenting

- Provide Medical Care to our Beneficiary Population – Over 8.5 Million
- Operate in a Peaceful and Hostile Environments
  - In Over 100 countries
- JOB #1 -- Support the Combat Troop
  - On Land
  - At Sea
  - In the Air

CORE COMPETENCIES

Data Quality Team


Patient Data
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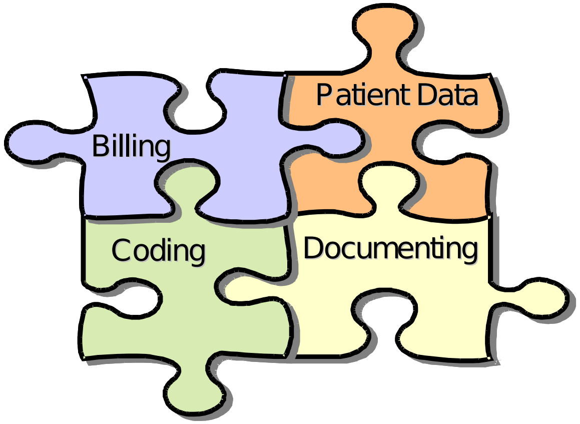
- Data Quality Manager
- Clinic Managers
- Credentials Manager
- Budget Analyst
- MEPRS Program Manager
- **Coding Supervisor**
- **Billing Supervisor**
- IM/IT Department
  - Including system administrators
- Others as needed
- Executive Committee – monthly oversight

CORE COMPETENCIES

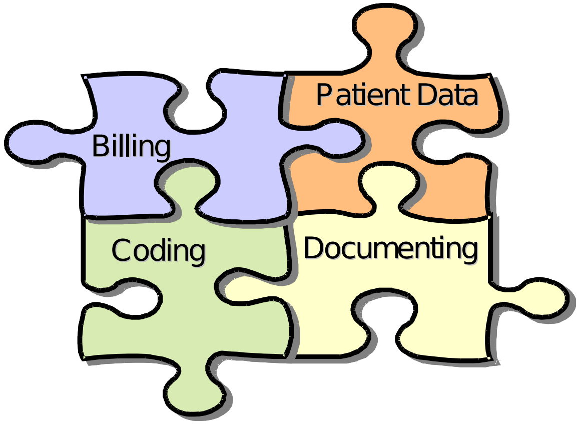
What are the Important Elements of Data Quality?


Billing
Patient Data
Coding
Documenting

- Provider Documentation
- Medical Records Control
- Accurate Coding
- Maximize Automation
  - Understand Your Data Flow
  - Ensure Your System Files and Tables are Set Up
  - User Training – Learn as much as you can!
- Data Integrity - This is the “VIEW”!

CORE COMPETENCIES

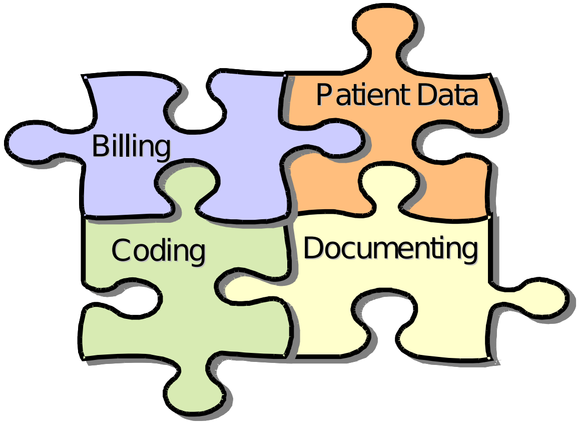
How do You Make Your MTF Look the Best?



- Take Ownership of YOUR Data!
- Ask yourself
    - How can I make the data better?
    - Are there computer limitations?
        - What are they?
        - Have I reported the issue to the MHS Helpdesk?
        - Have I reported the issue to my service POC for resolution?
    - What METRICS are directly effected by what I do?
- Get involved in the Data Quality Program

CORE COMPETENCIES

DQ Commander’s Checklist Question

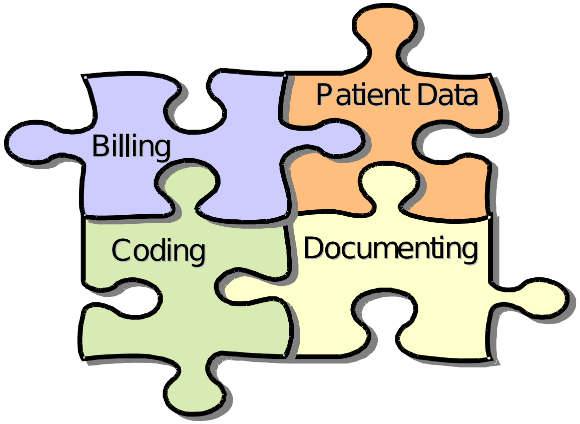


- **1a: What percentage of clinics have complied with "End of Day" processing requirements, "Every Clinic - Every Day"?**
- **1b: What percentage of appointments were closed in meeting your "End of Day" processing requirements?**

- **2a: What percentage of Outpatient Encounters, other than APVs, have been coded within 3 business days of the encounter?**
- **2b: What percentage of APVs have been coded within 15 days of the encounter?**
- **2c: What percentage of Inpatient records have been coded within 30 days after discharge?**

CORE COMPETENCIES

DQ Commander’s Checklist Question

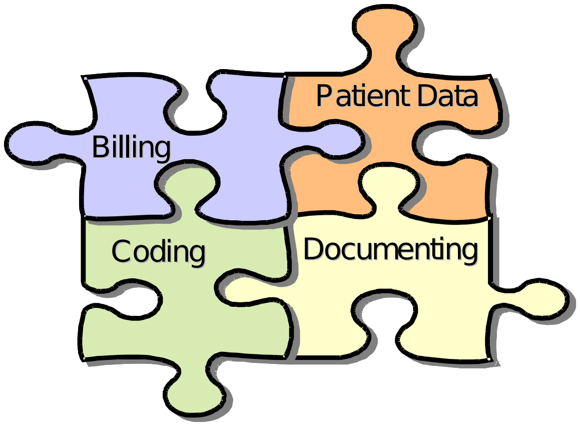


- **3a: Was monthly MEPRS/EAS financial reconciliation process completed?**
- **3b: Were monthly inpatient and outpatient workload reconciliation processes completed?**
- **3c: Were the data load status outlier/variance WWR-EAS IV and allocation tabs in the current MEWACS document reviewed and explanations provided for flagged data anomalies?**

- **4a: Timely submission of data - MEPRS/EAS**
- **4b: Timely submission of data - SIDR/CHCS**
- **4c: Timely submission of data - WWR/CHCS**
- **4d: Timely submission of data - SADR/ADM**

CORE COMPETENCIES

DQ Commander's Checklist Questions

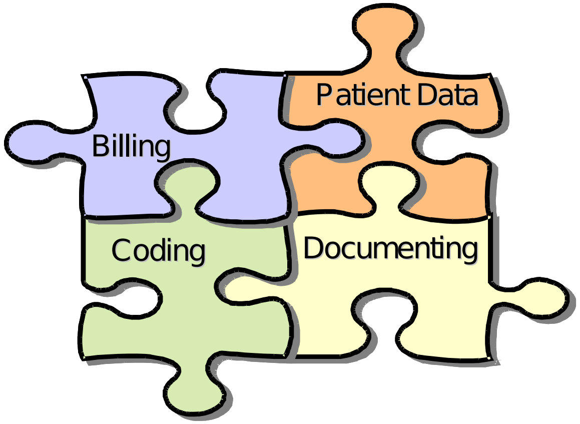


- **5. Outcome of monthly inpatient coding audit?**

- **6a: Percentage of medical records on-hand**
- **6b: E&M codes deemed correct**
- **6c: ICD codes deemed correct**
- **6d: CPT codes deemed correct**
- **6e: DD2569s deemed correct**

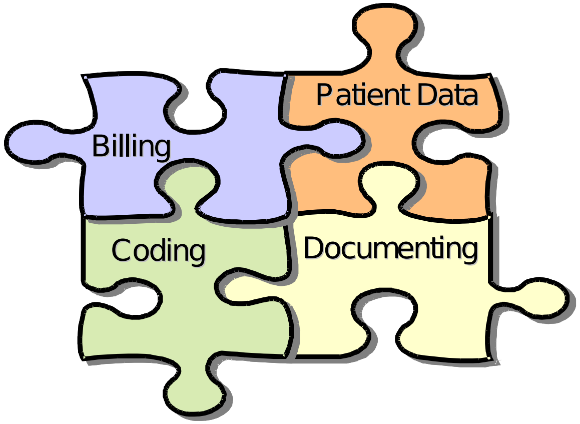
- **7a: #SADR encounters/#WWR visits**
- **7b: #SIDR dispositions/#WWR dispositions**
- **7c: #EAS visits/#WWR visits**
- **7d: #EAS dispositions/#WWR dispositions**

CORE COMPETENCIES



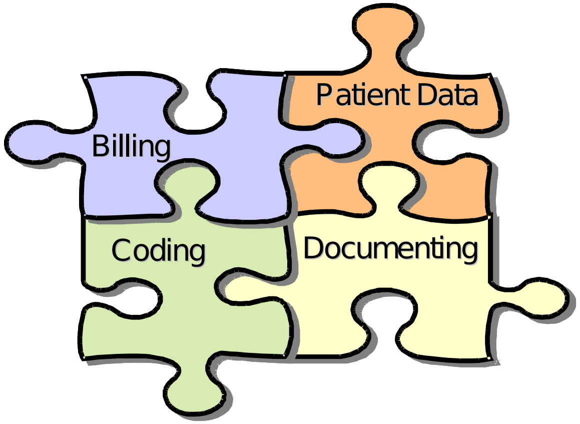
- Data quality begins with proper CHCS file/table set up
  - Provider/Clinic Profiles
  - Standardized Appointments
  - File/Table Build/Updates
- Assigning Workload to the proper MEPRS/FCC codes
  - Site Definable MEPRS Table
  - Inappropriate MEPRS Code by Location Report
- Coding Audits to ensure accuracy

CORE COMPETENCIES



- PCM/all others distinction
- Privileging process
- Non-credentialed provider profiles
- Provider types
  - Critical to assign provider type even though not a required field!
  - Adding providers to groups
- Set appointment types and workload types allowed
- Validate Provider Profiles on a regular basis
- Provider Specialty Codes will automatically populate the HIPPA Provider Codes in CHCS
- National Provider Index – Type 1 and Type 2

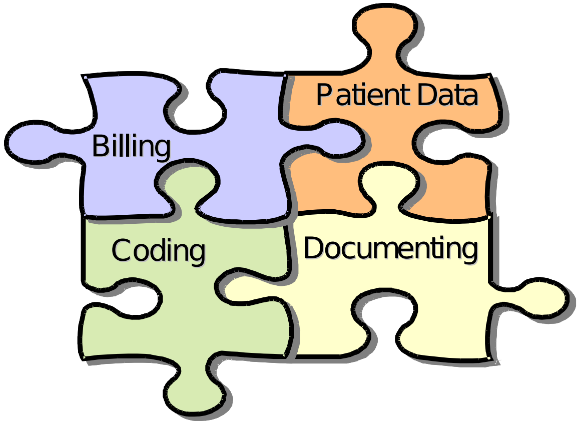
CORE COMPETENCIES



- Who inputs your provider file?
  - It should be your Credentials Office
- Things to improve your provider file
  - Be consistent
    - Last Name, First Name Middle Initial
    - Enter Provider Type – MD, PA, NP, DO…
    - Flag Provider – Provider/Non-Provider/Lab
    - Enter Provider Specialty Code (Be specific – not general)
      - All PA's – Provider Specialty Code 901
      - All Nurses (RNs) – Provider Specialty Code 600
      - All Technicians – Provider Specialty Code 900
- Provider Specialty Code effects your Budget

CORE COMPETENCIES

Pharmacy Data Quality Issues that directly Impact Billing



- Who is entering Civilian providers into the system? – Your Pharmacy Staff
- Have they been trained? – Survey says “NO”
- What Provider Specialty Codes are they using?
  - In the absence of guidance – Just about anything…mostly blank
  - Is there a policy? AF - YES
  - What is the fix?
    - Educate your pharmacy staff on how to input the provider files
    - Default Provider Specialty Code for Civilian Providers is 000 General Medical Officer or 001 Family Practice Physician

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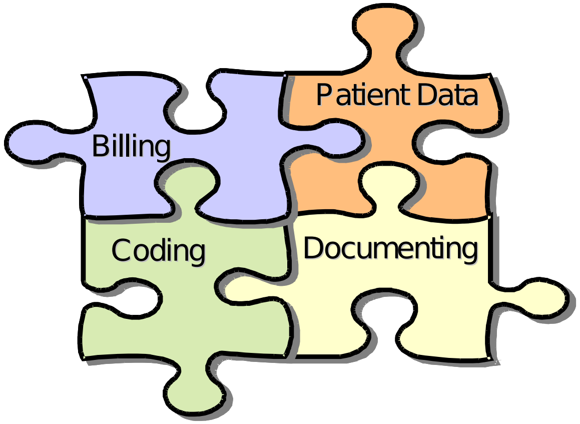
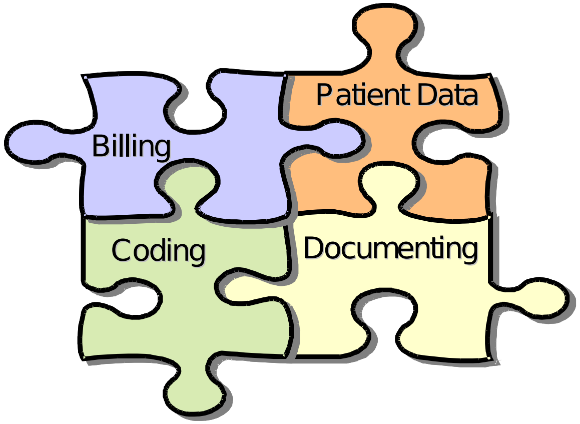


- Clinics Set up is Critical
  - Assign Appointment types
  - Assign Providers
  - Template Management
- Group vs. Place of Care
  - Place of Care is where workload is generated and assigned
- MEPRS Code assignment
  - Recommend MEPRS Program Manager is the only person to assign MEPRS codes
  - Must conform to WAM business rules or workload will not transmit to WWR or EAS IV
- ***Note if you use a MEPRS code that is for Minutes of Service – ZERO RVU credit***

CORE COMPETENCIES

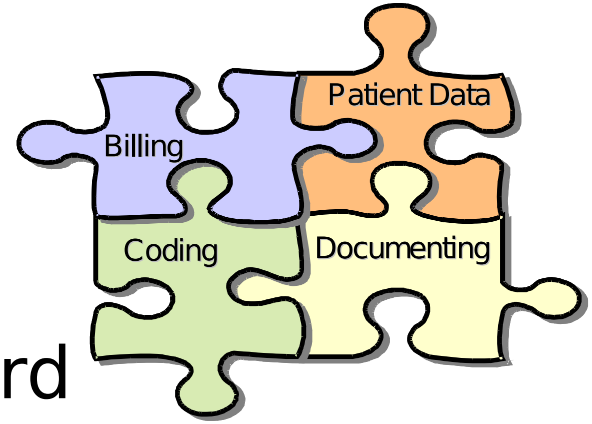


- Establish critical registration points
  - Limit to as few as possible
  - Ongoing training for all persons responsible for updating demographics
- Ensure even mini-reg functions are tightly controlled
- Update/Verify Patient Demographics each time a patient calls for an appointment
  - Don’t forget to verify their Other Health Insurance
  - Every non-active duty patient must have an DoD 2569 in their medical record and it must be less than 365 days old.
- Duplicate Patient Report
- Un-remarried Spouses – They have been changed to their own SSNs
- NEW DEERS

Did you update The PII file in CHCS?

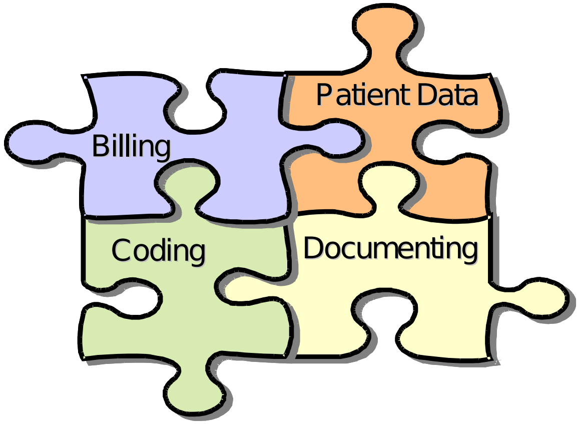
CORE COMPETENCIES

MEPRS Structure



- First 3 letters are DoD-standard (Army, Air Force, and Navy)
- First letter identifies MTF functional categories
- Second letter identifies Summary Accounts within MTF functional categories:
- The third letter identifies particular work centers within Summary Accounts
- 4-letter MTF-specific codes

C O R E C O M P E T E N C I E S


Patient Data
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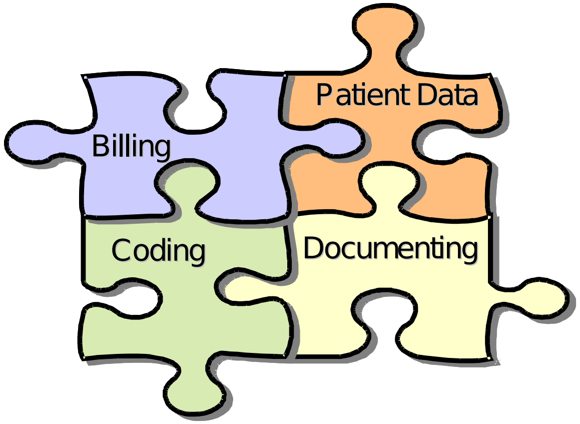
- Final Operating Accounts
  - A - Inpatient Care
  - B - Ambulatory Care
  - C - Dental Care
  - F - Special Programs
  - G - Medical Readiness

- Intermediate (Stepdown) Accounts
  - D - Ancillary Services
  - E - Support Services

CORE COMPETENCIES


Patient Data
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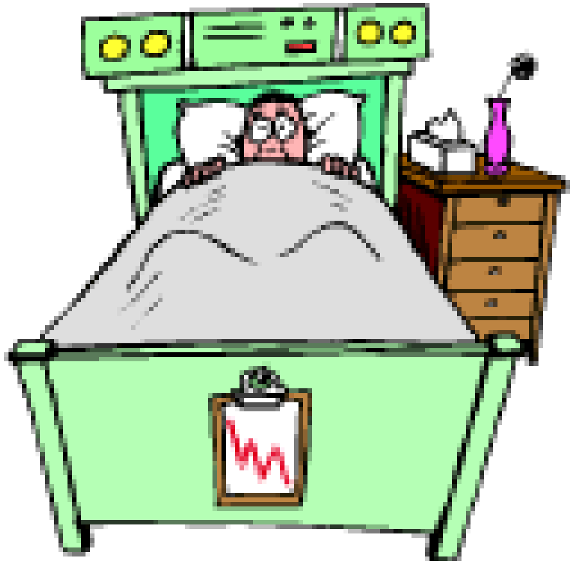
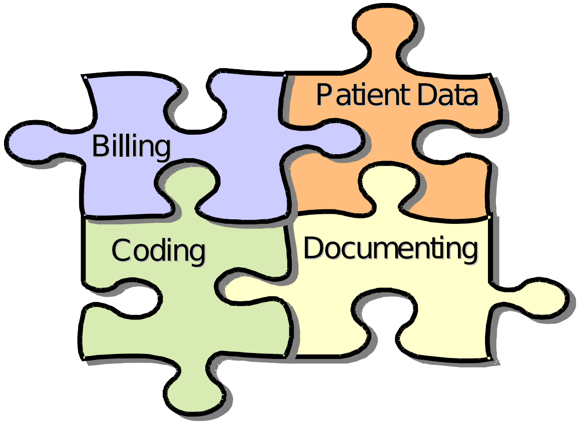
- Second letter identifies Summary Accounts within MTF functional categories:
  - A = INPATIENT CARE
    - AA = Medical Care
    - AB = Surgical Care
    - AC = Obstetrical//Gynecological Care
    - AD = Pediatric Care
    - AE = Orthopedic Care
    - AF = Psychiatric Care
    - AG = Family Practice Care



CORE COMPETENCIES


Patient Data
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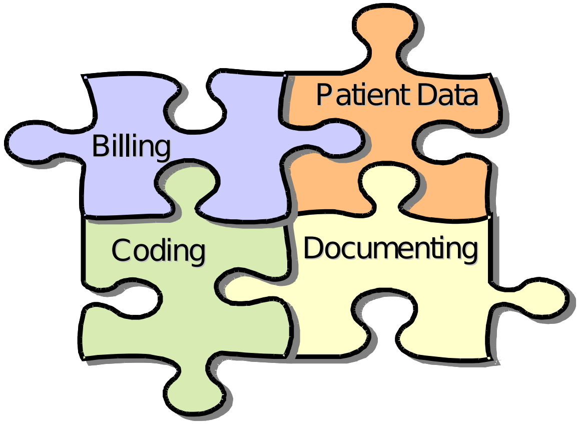
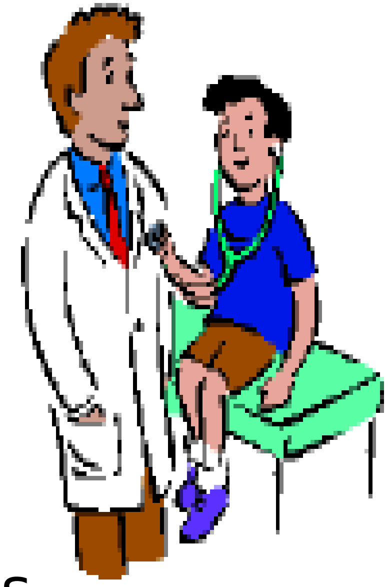
- The third letter identifies particular work centers within Summary Accounts:
  - A = INPATIENT CARE
    - AA = MEDICAL CARE
      - **AAA = Internal Medicine**
      - **AAB = Cardiology**
      - **AAD = Dermatology**
      - **AAE = Endocrinology**
      - **AAF = Gastroenterology**
      - **AAG = Hematology**

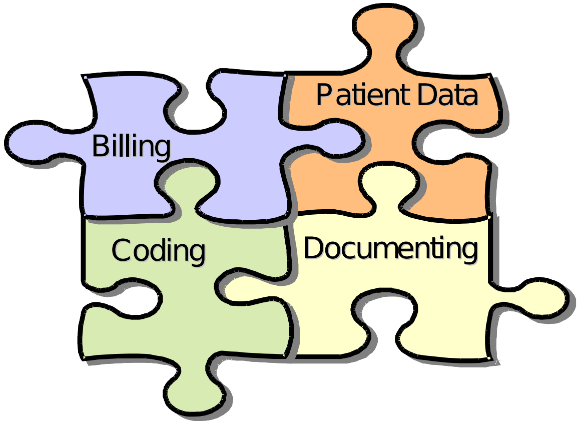


- B = OUTPATIENT CARE
  - BA = Medical Care
  - BB = Surgical Care
  - BC = Obstetrical//Gynecological Care
  - BD = Pediatric Care
  - BE = Orthopedic Care
  - BF = Mental Health Care
  - BG = Family Practice Care
  - BH = Primary Medical Care
  - BI = Emergency Medical Care
  - BJ = Flight Medicine Care
  - BK = Undersea Medicine Care
  - BL = Rehabilitative Ambulatory Services



CORE COMPETENCIES

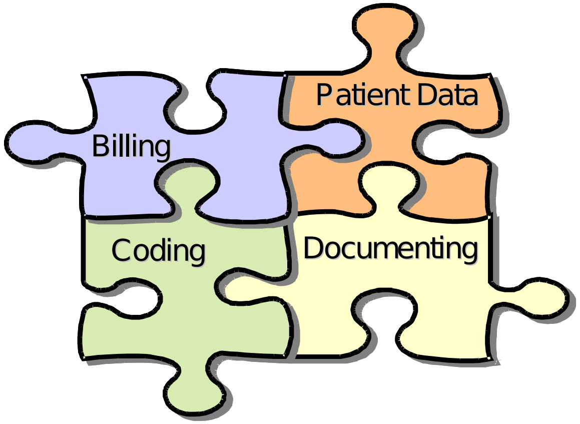
TIME Reporting



- **DQ Risk Areas (See RVU/FTE/Day)**
  - **DHP Metric: Provider RVU/FTE/Day dependent upon accurate reporting of Clinic Available Time, to the clinical work center where the work was actually performed:**
    - Inpatient Clinical Service
    - Outpatient Clinic(s)
    - Ambulatory Procedure Visits
    - Observations
  - Support Staff FTEs -- How much time were they available to the clinic?
- **Impacts**
  - **Cost per Visit**
  - **Cost per CPT**
  - **Cost per Occupied Bed Day**
  - **Provider RVU/FTE/Day**

CORE COMPETENCIES

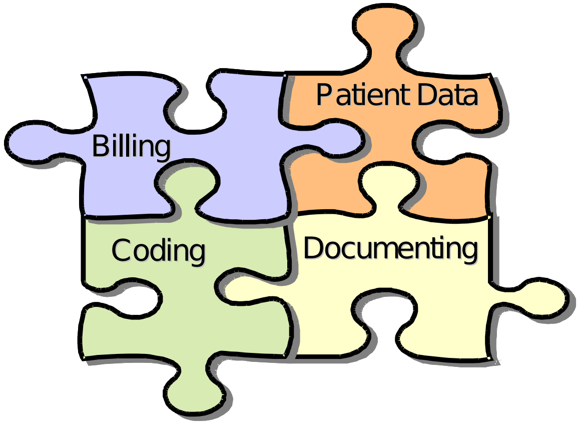
Billing Hints



- Encounters run the gauntlet
- Parts of the Logic Gauntlet are:
  - Is the Provider Specialty Code less than 905?
    - Yes – Pass to next level;   No – stop
  - What is the Provider type (CMAC Class)? Billable Type, i.e. MD, DO…
    - Yes – Pass; No - stop
  - What is the Provider Flag? Provider?
    - Yes – Pass; No - stop
  - Is the visit count?
    - Yes – Pass; No – stop
    - Note: Some non-count workload is billable - manually
  - Myth: Since TFL everyone is dropping their OHI. Reality: Many of them are, however, since we have never done a good job at capturing OHI information the number of beneficiaries with OHI is rising.

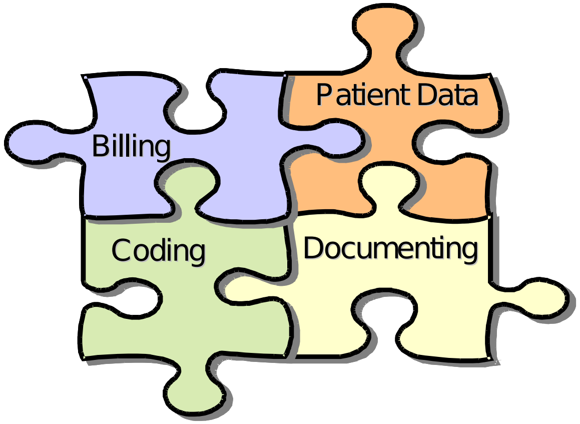
CORE COMPETENCIES

What is your Data Used For?



- Population-based Healthcare Delivery
  - Forecast demand and track delivery of preventive services
  - Manage chronic disease/conditions
- Monitor efficiency of the healthcare system
- Provider/Clinic Productivity
- Medicare Accrual Fund
- Performance Based Budgeting – ODRA/PPS
- Reimbursements: Third Party Collections, Inpatient, CG/NOAA/PH Collections, Pay Patients, Foreign Patients
- Reduce claims denial
- Document Level of Effort by all clinic staff
- Enable the Leadership to make informed decisions

CORE COMPETENCIES


Billing
Patient Data
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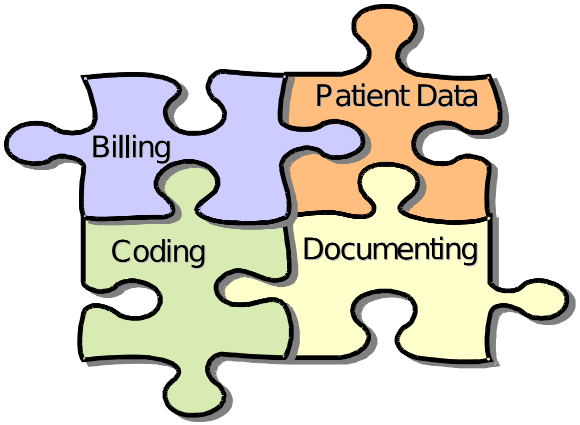
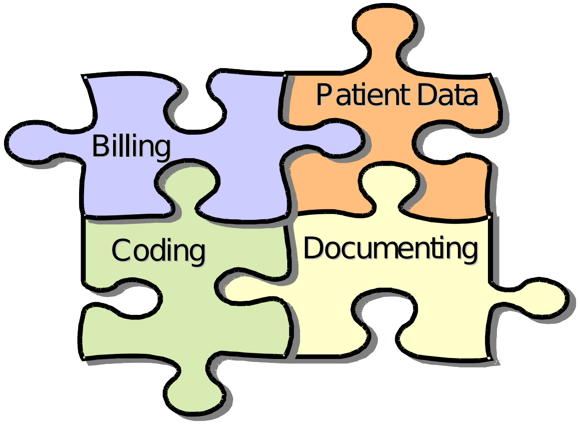
FEE for Service

CORE COMPETENCIES



- Top Five Up Coded E&M Codes for Nurses
  - Telephone Consults – 90%
    - 99371 – 84% Simple
    - 99372 – 4% Intermediate
    - 99371 – 2% Complex
  - 99213 – 4% … Low to Moderate Severity. Physician typically …
  - 99412 – 2% Preventive medicine counseling …
  - 99212 – 1% … Self limited or Minor. Physician typically …
  - 99214 – 1% … Moderate to high severity. Physician typically …
- Top Five Up Coded E&M codes for Technicians
  - 99213 – 40% … Low to Moderate Severity. Physician typically …
  - 99212 – 14% … Self limited or Minor. Physician typically …
  - 99214 – 11% … Moderate to high severity. Physician typically …
  - Telephone Consults (99371/2/3) – 7%
  - 99395 – 6% Periodic comprehensive preventive … 18-39 years old

CORE COMPETENCIES


Patient Data
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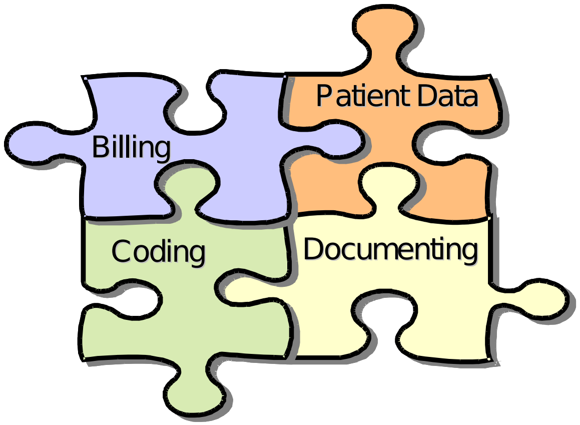
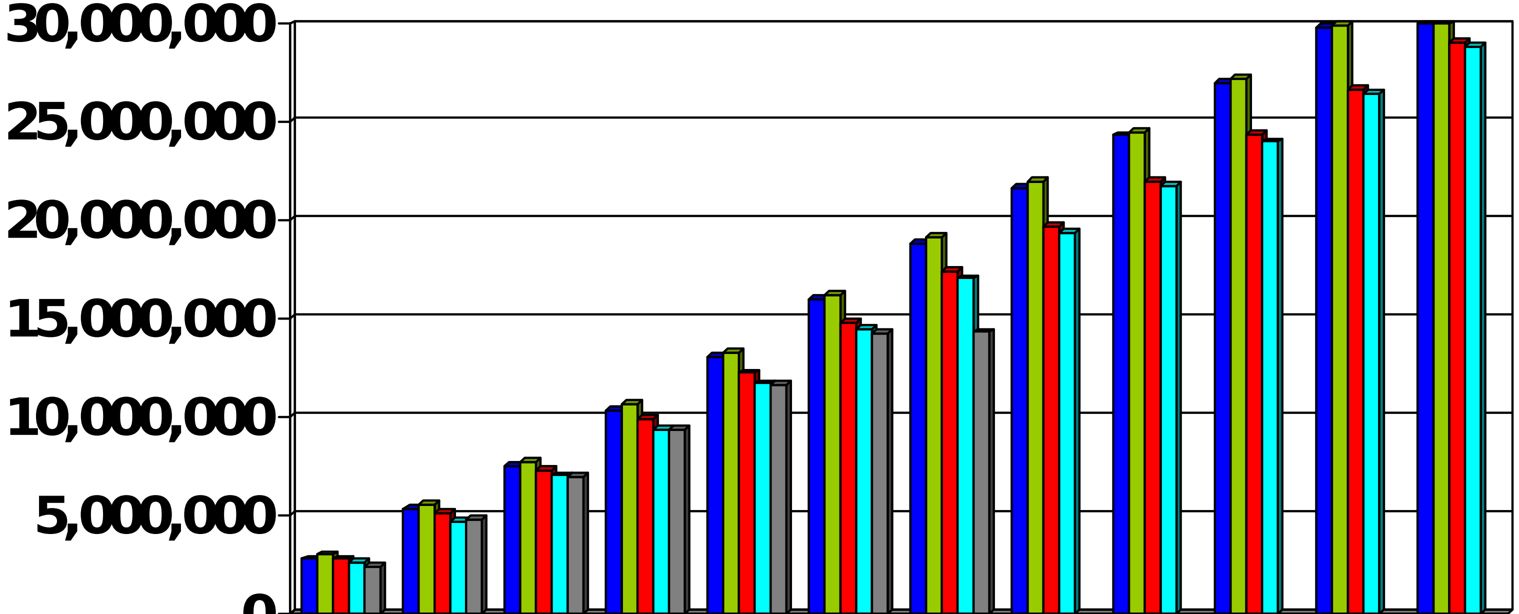
- Nurses and Techs Earn
- Using 99211 - **.17 RVUs** for their Clinic
- Earn RVUs for CPTs

- Not billable on their own!

CORE COMPETENCIES

Relative Value Unit (RVU) Report MHS





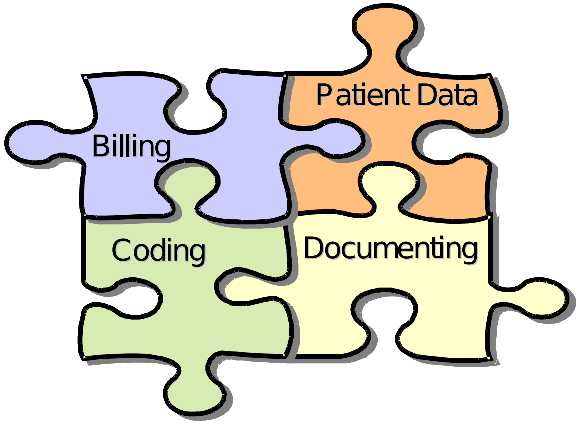
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	2,728,24	5,297,16	7,472,14	10,337,5	13,006,3	16,002,6	18,779,7	21,656,7	24,316,2	26,949,5	29,831,1	32,129,4
🟩 FY02	2,945,62	5,541,31	7,729,61	10,605,1	13,295,1	16,172,8	19,149,7	22,002,1	24,519,3	27,197,9	29,893,3	32,465,6
🟥 FY03	2,731,68	5,055,37	7,233,96	9,844,16	12,226,5	14,803,3	17,361,1	19,702,8	21,989,6	24,336,4	26,651,9	29,043,9
🟦 FY04	2,552,38	4,680,50	6,978,50	9,313,96	11,678,9	14,475,5	17,015,5	19,324,3	21,729,2	23,999,2	26,423,1	28,803,1
⬜ FY05	2,380,49	4,731,74	6,924,49	9,336,48	11,650,8	14,223,0	14,295,2					

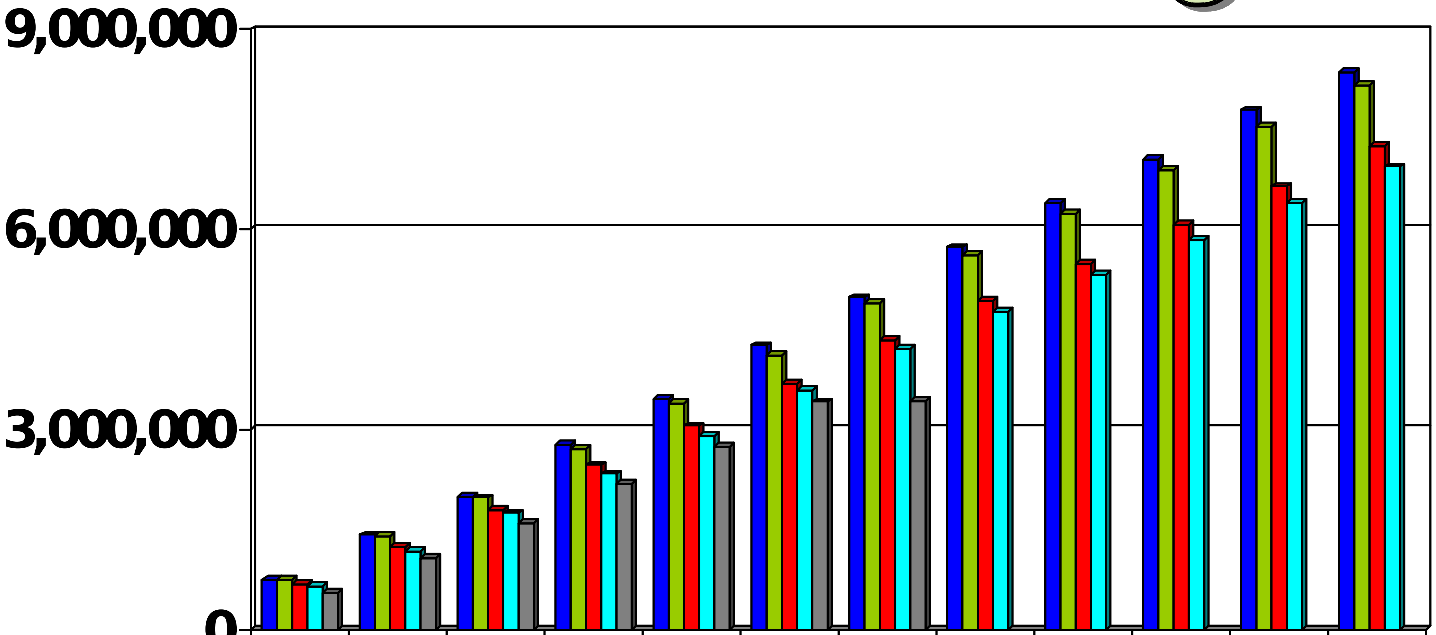
Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

CORE COMPETENCIES

Relative Value Unit (RVU) Report AFMS





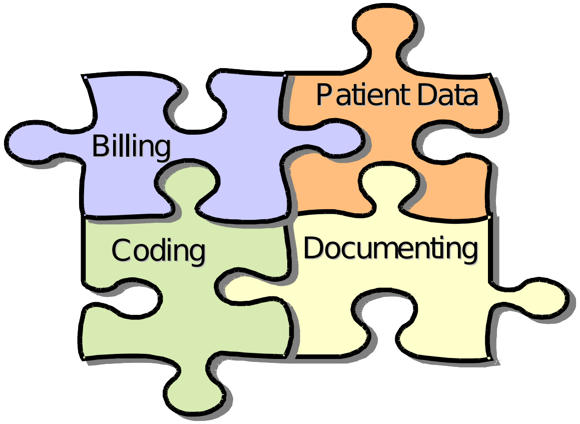
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
■ FY 01	729,482.	1,408,87	1,989,43	2,756,90	3,465,53	4,253,46	4,976,74	5,726,50	6,394,34	7,049,59	7,789,06	8,346,21
■ FY02	744,084.	1,397,00	1,967,43	2,711,73	3,398,61	4,119,21	4,880,45	5,606,02	6,221,70	6,874,47	7,542,24	8,171,94
■ FY03	672,016.	1,240,29	1,797,03	2,455,50	3,047,94	3,690,45	4,335,11	4,914,79	5,484,04	6,065,13	6,641,81	7,250,90
■ FY04	643,314.	1,160,97	1,737,94	2,323,17	2,905,65	3,585,84	4,206,16	4,752,23	5,316,04	5,831,28	6,399,34	6,936,60
■ FY05	546,573.	1,075,87	1,587,76	2,171,31	2,746,21	3,402,13	3,421,62					

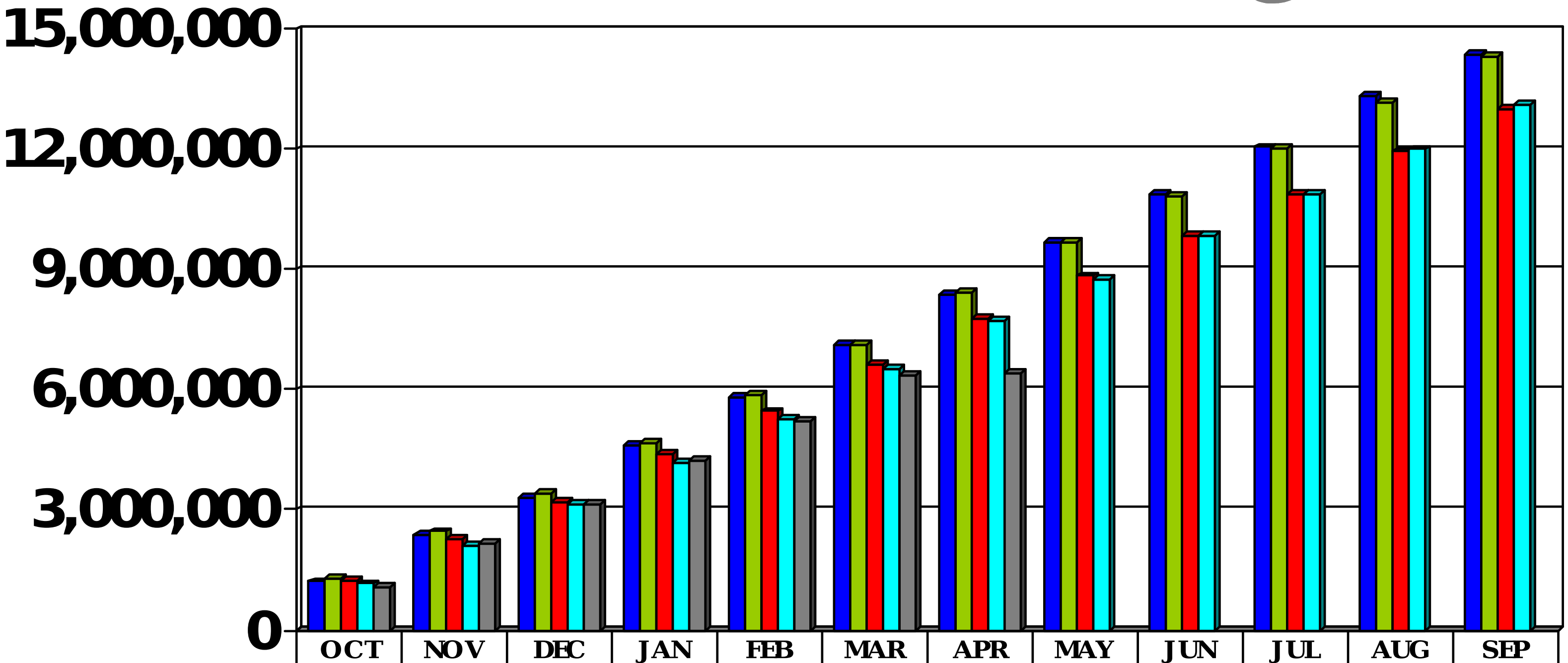
Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

CORE COMPETENCIES

Relative Value Unit (RVU) Report Army





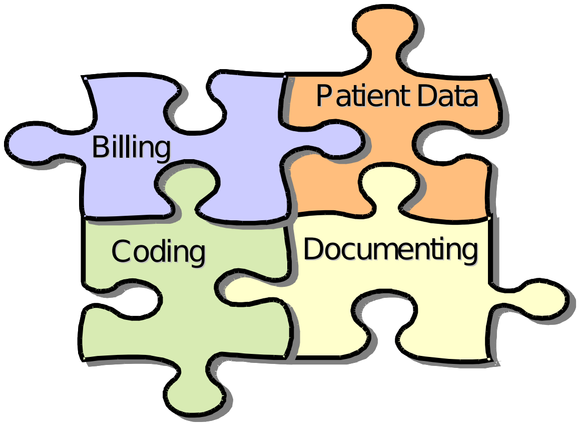
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	1,206,83	2,357,42	3,318,99	4,601,53	5,797,09	7,139,88	8,390,25	9,679,05	10,871,1	12,047,1	13,319,1	14,364,5
🟩 FY02	1,302,94	2,452,87	3,400,66	4,672,09	5,843,62	7,125,14	8,436,25	9,687,83	10,812,6	12,004,8	13,181,3	14,321,3
🟥 FY03	1,212,67	2,254,33	3,207,44	4,379,42	5,450,99	6,616,43	7,774,29	8,832,80	9,855,34	10,898,7	11,945,8	13,026,3
🟦 FY04	1,145,43	2,110,81	3,138,14	4,185,49	5,258,36	6,529,63	7,700,15	8,747,89	9,849,59	10,893,0	11,999,4	13,095,1
⬜ FY05	1,079,18	2,149,94	3,135,90	4,210,04	5,228,49	6,372,93	6,404,74					

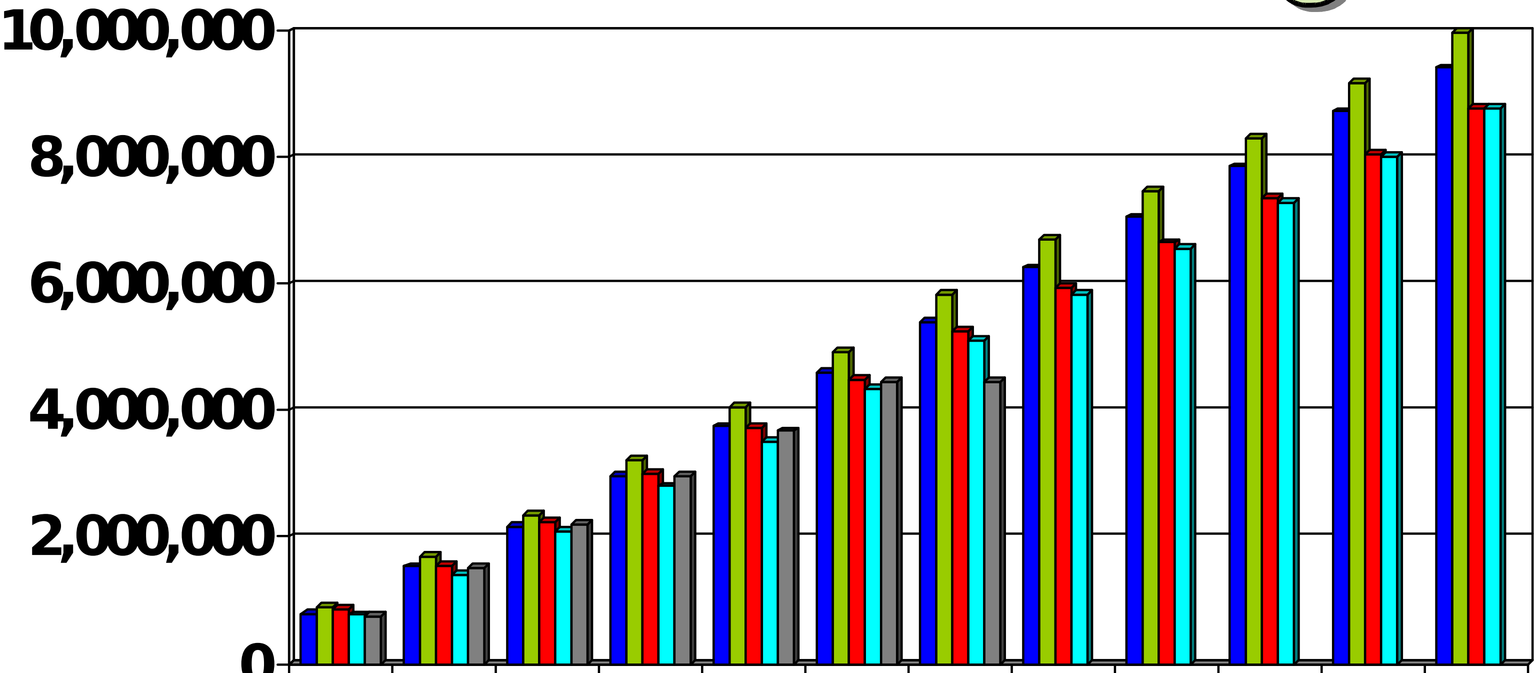
Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

CORE COMPETENCIES

Relative Value Unit (RVU) Report Navy





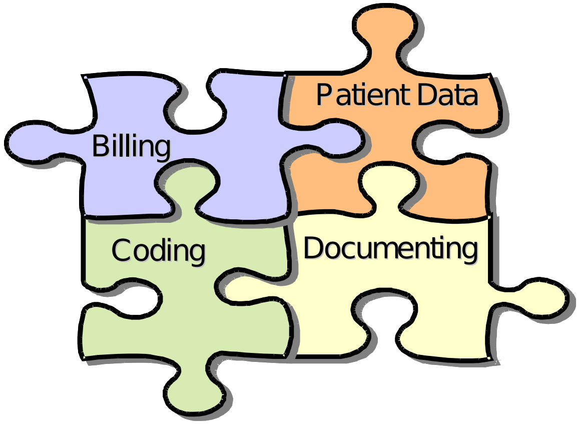
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	791,920.	1,530,86	2,163,71	2,979,09	3,743,72	4,609,29	5,412,70	6,251,22	7,050,73	7,852,81	8,722,99	9,418,71
🟩 FY02	898,597.	1,691,43	2,361,52	3,221,34	4,052,90	4,928,48	5,833,03	6,708,25	7,485,03	8,318,57	9,169,77	9,972,36
🟥 FY03	846,992.	1,560,74	2,229,48	3,009,23	3,727,62	4,496,47	5,251,69	5,955,22	6,650,22	7,372,49	8,064,24	8,766,67
🟦 FY04	763,638.	1,408,71	2,102,42	2,805,30	3,514,90	4,360,04	5,109,20	5,824,22	6,563,58	7,274,86	8,024,35	8,771,34
⬜ FY05	754,740.	1,505,92	2,200,82	2,955,12	3,676,13	4,447,97	4,468,82					

Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

C O R E

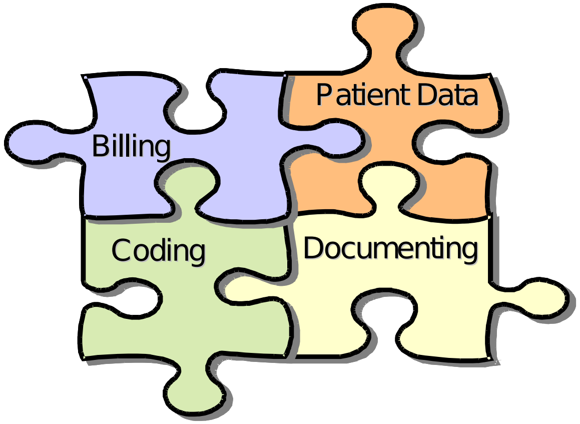
C O M P E T E N C I E S


Patient Data
Billing
Coding
Documenting

No such thing as:

“It’s not my job”

CORE COMPETENCIES


Patient Data
Billing
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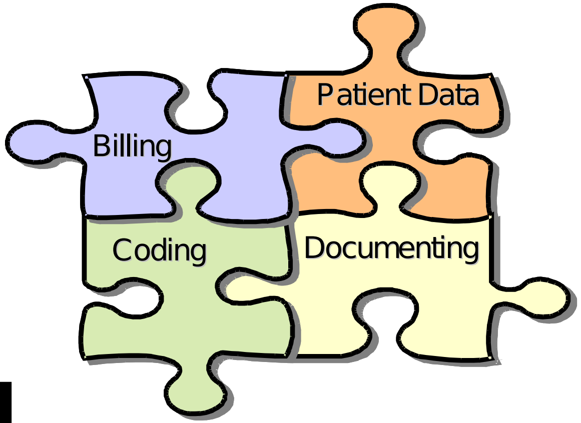
Documenting

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

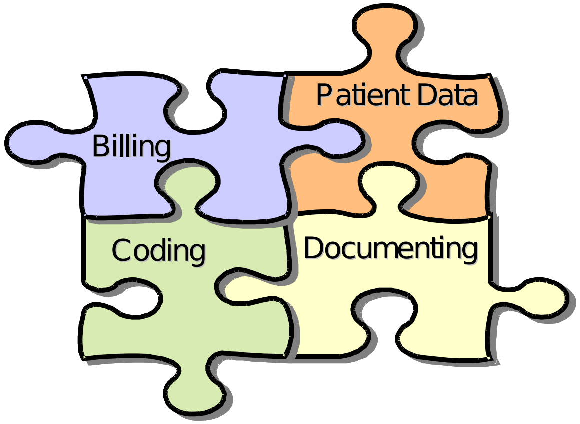
Industry Based Workload Alignment (IBWA) – Update

Ron James

W2-0900-0950

CORE COMPETENCIES

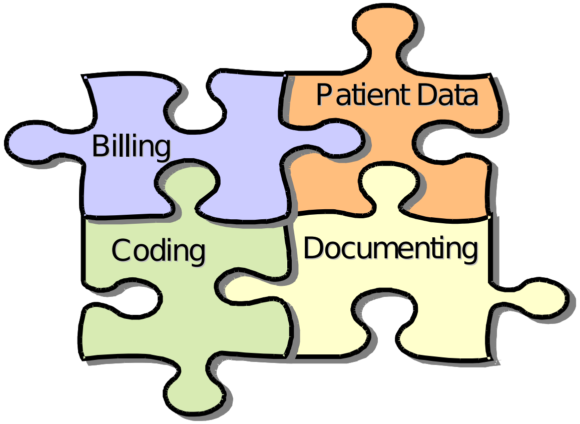
Purpose


Patient Data
Billing
Coding
Documenting

To familiarize personnel with the business rules and the ADM capability to create, modify and cancel Rounds (RNDS) encounters in order to capture inpatient professional services data for subsequent transmission to the M2 via the Standard Ambulatory Data Record (SADR).

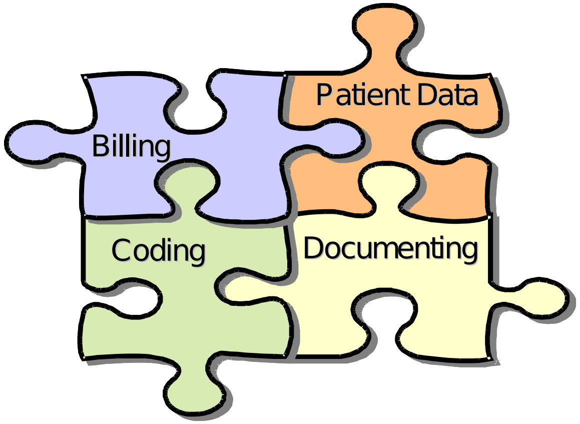
C O R E C O M P E T E N C I E S

Objectives


Patient Data
Billing
Coding
Documenting

- Provide background on the IBWA initiative.
- Introduce the RNDS encounter
- Discuss Business Rules
- Discuss Compliance and Use of the Data

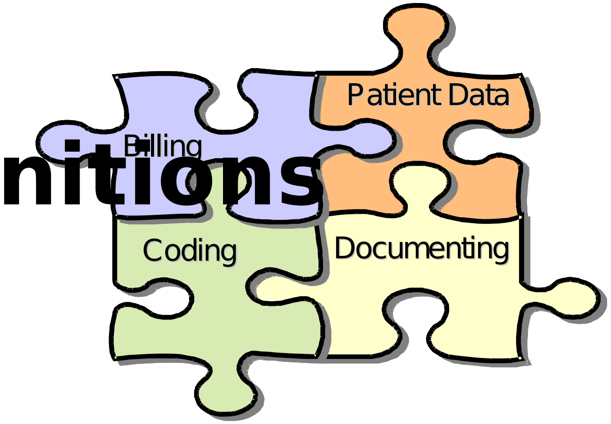
Background



- IBWA is a strategic initiative to align the MHS with the civilian sector and pave the way for inpatient itemized billing.
- Coding inpatient professional services is a step towards that goal.
- The location of healthcare delivery does not change the professional services coding process.

CORE COMPETENCIES

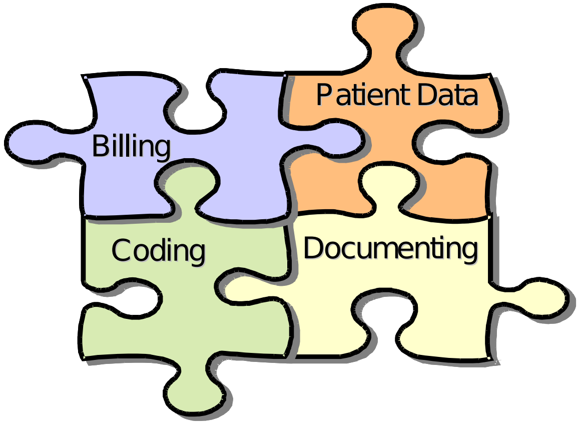
Background Definitions



- Institutional Services are healthcare provided by non-privileged providers/staff, interns, residents, and fellows. It includes resources associated with equipment, facilities, utilities and supplies that are utilized or consumed during a patient’s encounter with the healthcare system.
- Professional Services are healthcare provided directly to the patient by an individually privileged provider. Excludes services provided by interns, residents, fellows and any Graduate Medical Education (GME) staff.

CORE COMPETENCIES

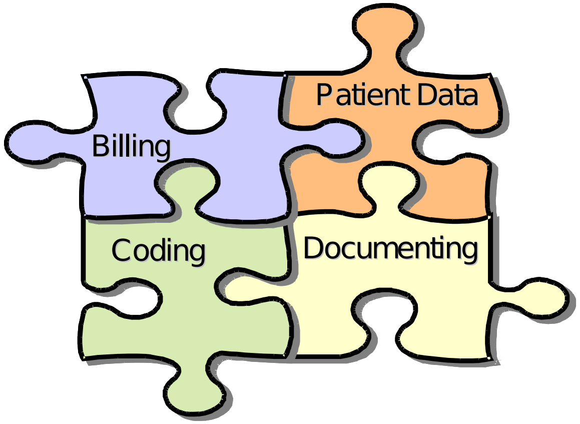
Background
Guidance for Change



- The Unified Biostatistical Utility (UBU) workgroup was tasked with developing a means for capture of inpatient professional services using existing systems.
- The original guidance was signed on 2 October 2002.
- IBWA relates only to the capture of inpatient encounters.

CORE COMPETENCIES

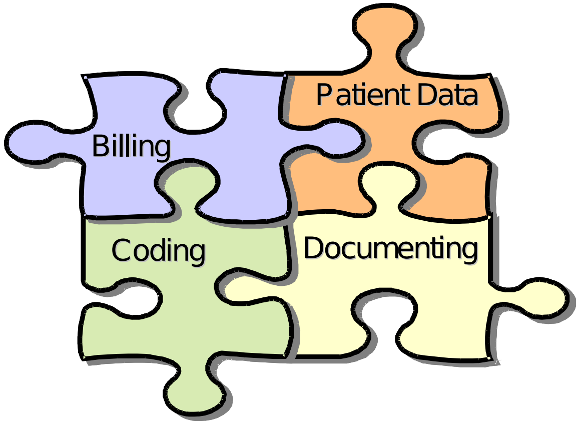
CHCS Rounds (RNDS) Encounter



- IBWA implements a new appointment type for IBWA rounds encounters – RNDS.
- A RNDS encounter will be created automatically when
  - Patient is admitted (provider = Admitting Provider).
  - Upon inpatient transfer that includes a change of MEPRS code/clinical service.
  - Nightly for every inpatient at the census time (provider = Attending).

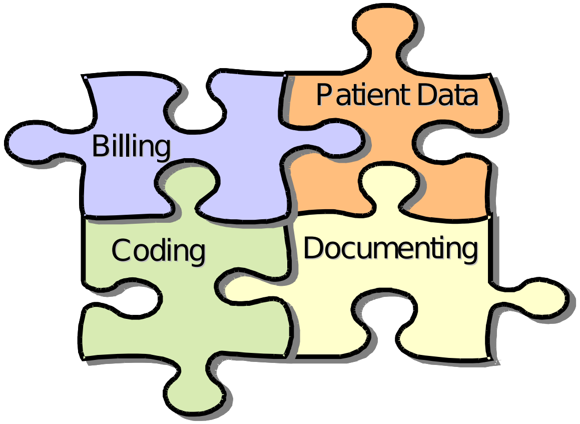
CORE COMPETENCIES

RNDS Encounter & PAD



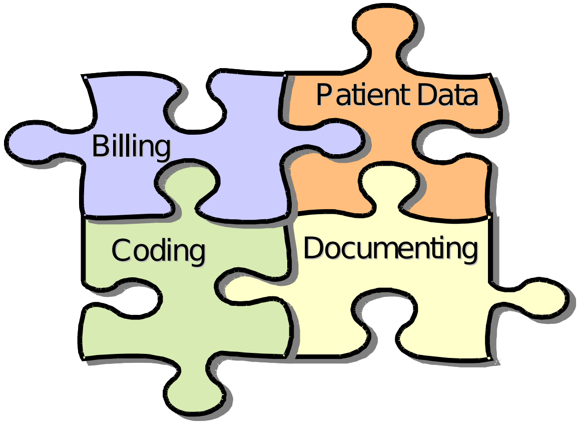
- Highly dependent upon timely and accurate entry into CHCS of Admission, Discharge and Transfer events.
- Accurate designation of Admitting and Attending Physicians.
- Accurate entry of the clinical service “A” MEPRS code at time of admission and any time the clinical service changes throughout the inpatient episode.

Using the RNDS Encounter



- Attending/consulting providers will document patient interactions in the inpatient medical record.
- The RNDS encounter is then coded in ADM based upon the documentation in the medical record.
  - Interns, residents and fellows cannot be the sole provider recorded for a RNDS encounter.
  - If the attending provider is not present during the encounter, then the RNDS encounter should be cancelled.
- RNDS encounters will be available for completion for a maximum of 30 days after the patient is discharged.
- After the 30 day period, any uncoded RNDS encounters will be automatically cancelled by the system.

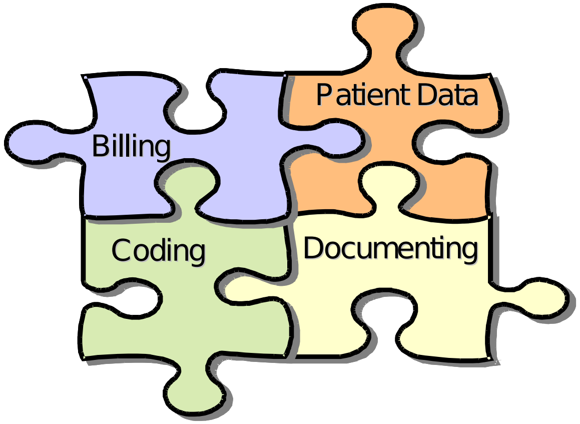
RNDS Encounter Creation Rules



- RNDS encounters will be created automatically at the census hour each day.
- A RNDS encounter can also be created manually using the ADM “RNDS Appointment Processing Menu.”
- A RNDS encounter can never be “future.”
- The “A” MEPRS Code recorded at the time of admission or later assigned due to a change or correction will be used for the RNDS encounter, regardless of the service/specialty conducting the rounds.

CORE COMPETENCIES

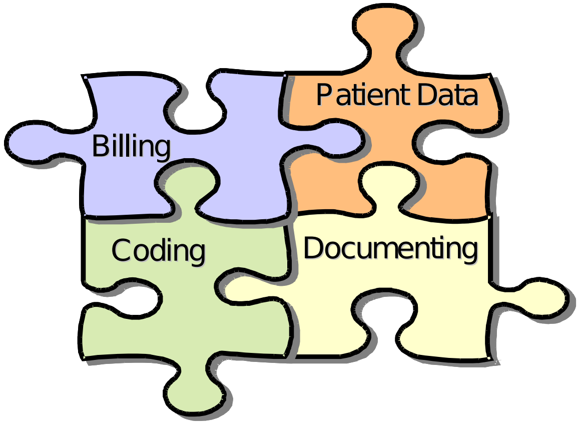
Rounds vs. Inpatient Consults


Patient Data
Billing
Coding
Documenting

- Note that the RNDS encounter only applies to rounds.
- RNDS encounters do not replace Inpatient Consults.
- Monitor IBWA rounds to spot coding variation and to ensure that workload is not lost.

CORE COMPETENCIES

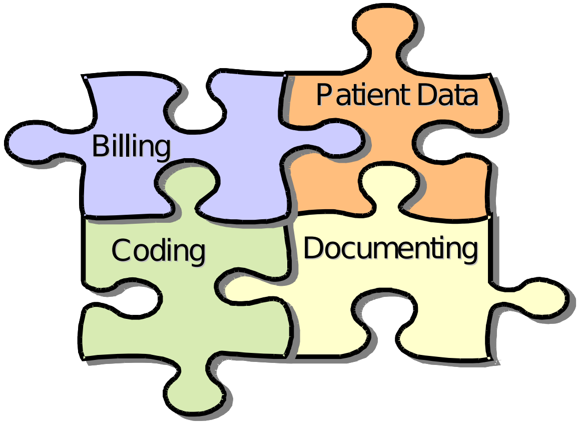
Coding the RNDS Encounter



- IBWA rounds can be done either retrospectively or concurrently.
- Up to 2 additional providers may be listed on the encounter with additional E&M codes and CPT codes.
- MTFs should consider developing coding templates for the IBWA Clinic just as they do for other clinics in ADM.

CORE COMPETENCIES

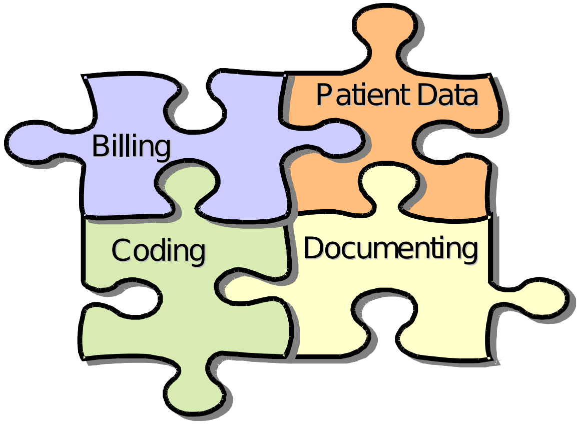
Coding RNDS in ADM


Patient Data
Billing
Coding
Documenting

- ADM will require a disposition status to be entered for every RNDS encounter.
  - Transferred to another hospital
  - Transferred to a SNF
  - Transferred to another clinical service
  - Continued stay
  - Left against medical advice
  - Discharged Home
  - Expired

CORE COMPETENCIES

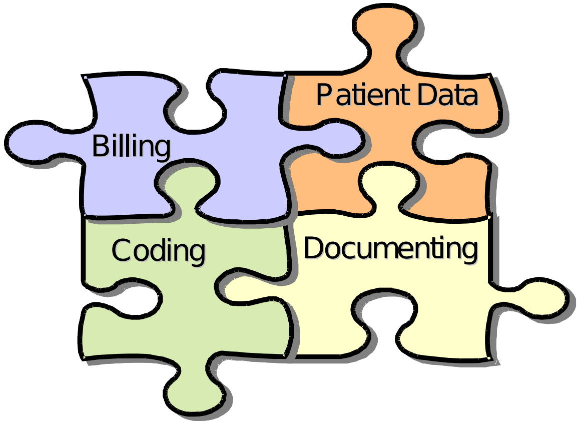
Coding Continued


Patient Data
Billing
Coding
Documenting

- Subsequent rounds interactions are captured by additional E&M codes, cumulative ICD-9-CM and CPT codes.
- Unless there is a change in clinical service (MEPRS) all providers performing rounds should be reflected on the same RNDS encounter.

CORE COMPETENCIES

Current Compliance

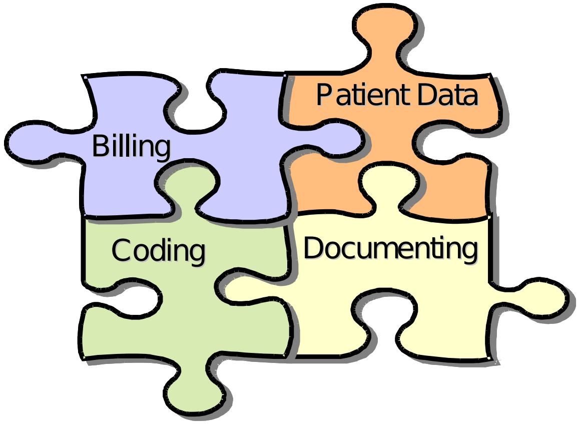


- Current Compliance is highly variable
  - Ranging from 5% to 274%
  - Consultations are being included in the IBWA rounds – **SHOULD NOT BE**
  - Rounds are being created for providers other than the Attending

Workload vs. Clinical documentation requirements: **NO SINGLE RIGHT ANSWER**

CORE COMPETENCIES

Calculation Methodology


Patient Data
Billing
Coding
Documenting

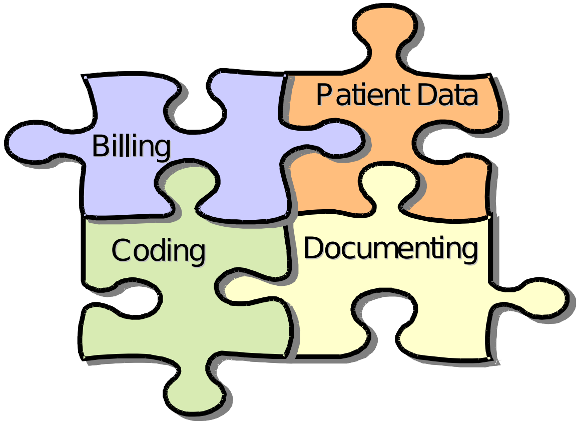
- DQMCP:
  - Total “A” SADRs

    Total Bed Days

- Most accurate:
  - Total “A” SADRs

    Total Bed Days + Total Dispositions

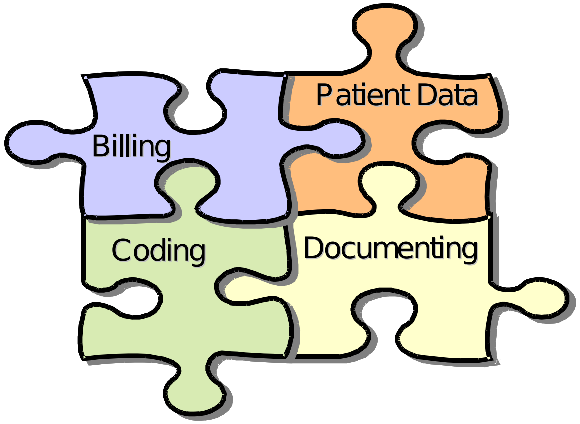
Proposed Changes


Patient Data
Billing
Coding
Documenting

- Permit Residents to create IBWA round when there is no Attending Note for a given hospital day.
  - Permits credit for work performed for PPS and Valuation metrics
  - Billing would have to be monitored once Inpatient Professional Services are billable by the MHS

CORE COMPETENCIES

Questions?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Billing
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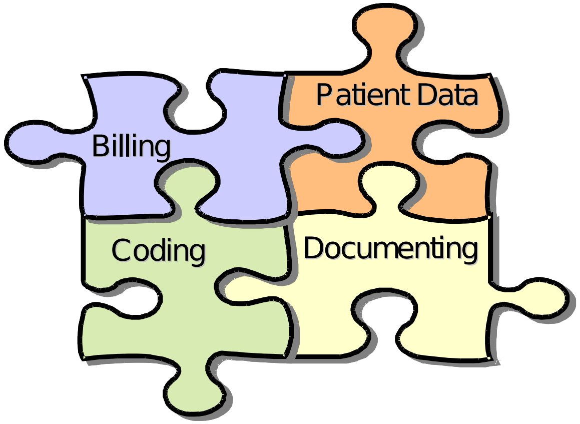
Documenting

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

Low Hanging Fruit

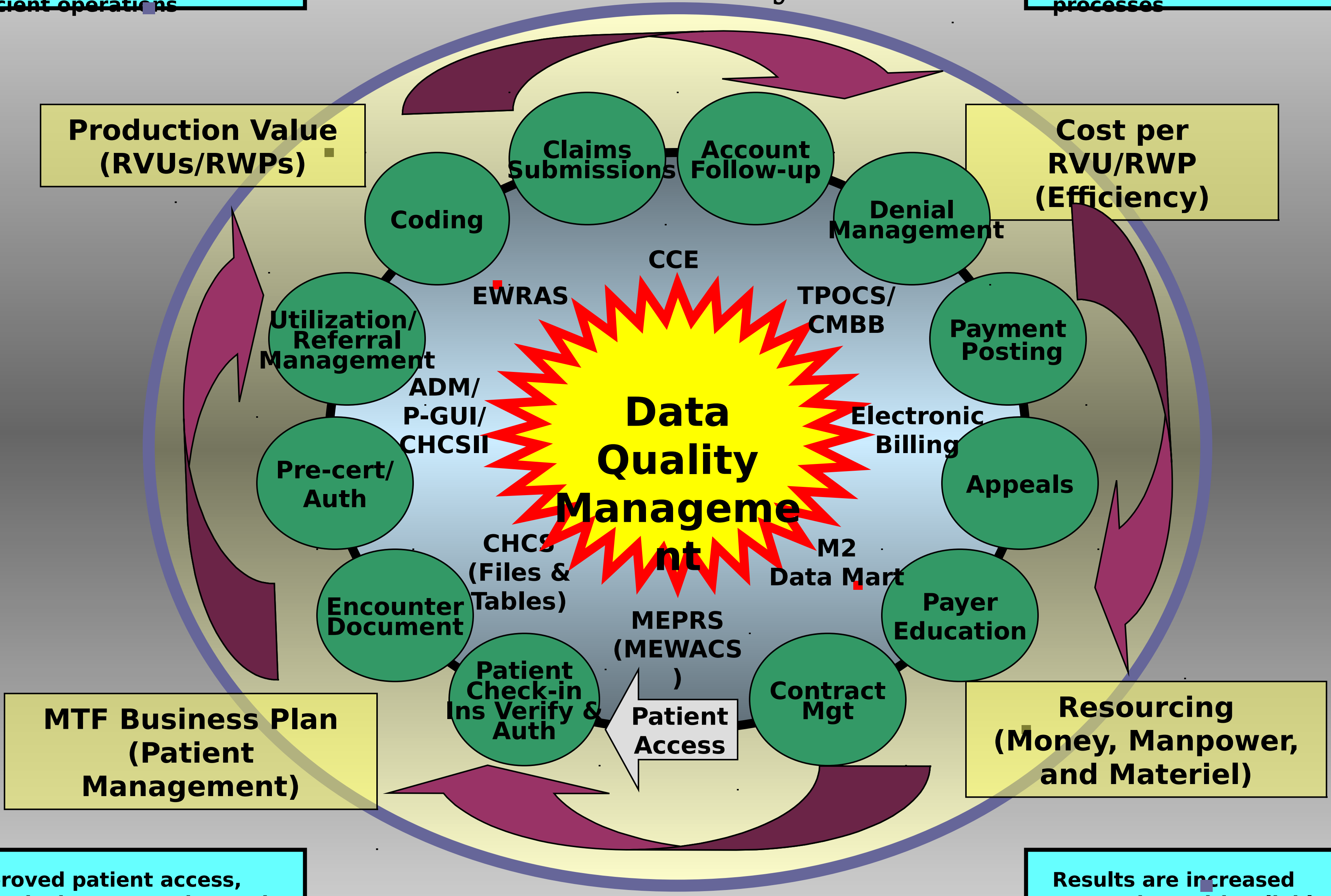
MSgt JoAnn Milster
Air Force Data Quality Manager
aka Green Eyeshade Monster

Date of Briefing
Track (e.g., Track 1, UBU)

Data quality Management Controls are the driving force and conduit for ensuring effective and efficient operations

MTF Patient Accounting & Revenue Cycle

Visual review for validating and streamlining major clinical business and resource management processes



Production Value (RVUs/RWPs)

Cost per RVU/RWP (Efficiency)

MTF Business Plan (Patient Management)

Resourcing (Money, Manpower, and Materiel)

Claims Submissions

Account Follow-up

Denial Management

Payment Posting

Appeals

Payer Education

Contract Mgt

Patient Check-in Ins Verify & Auth

Encounter Document

Pre-cert/ Auth

Utilization/ Referral Management

Coding

CCE

TPOCS/ CMBB

Electronic Billing

M2 Data Mart

MEPRS (MEWACS)

CHCS (Files & Tables)

ADM/ P-GUI/ CHCSII

EWRAS

Data Quality Management

Patient Access

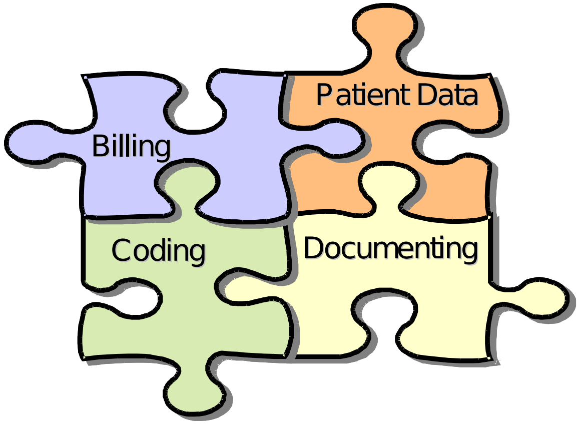
Improved patient access, records documentation and coding accuracy

Results are increased resourcing with reliable outcomes in the form of usable data

AFMSA/SGSR

CORE COMPETENCIES

What is Data Quality?


Patient Data
Billing
Coding
Documenting

- Is the accurate reflection of the work performed in the MTF that can be used to make informed leadership/management decisions at all levels of command.

It is the view of your MTF from the “Ivory tower”

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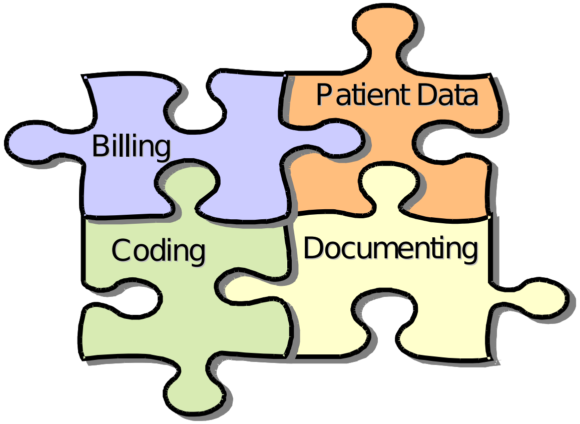
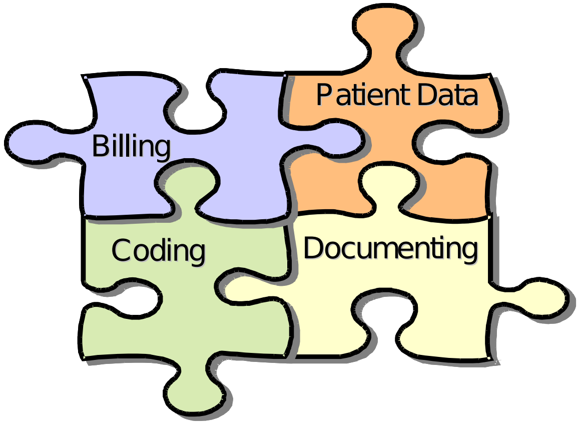
What is your data used for?



- Population-based Healthcare Delivery
  - Forecast demand and track delivery of preventive services
  - Manage chronic disease/conditions
- Monitor efficiency of the healthcare system
- Provider/Clinic Productivity
- Medicare Accrual Fund
- Performance Based Budgeting – PPS
- Reimbursements: Third Party Collections, Inpatient, CG/NOAA/PH Collections, Pay Patients, Foreign Patients
- Reduce claims denial
- Document Level of Effort by all clinic staff
- Enable the Leadership to make informed decisions

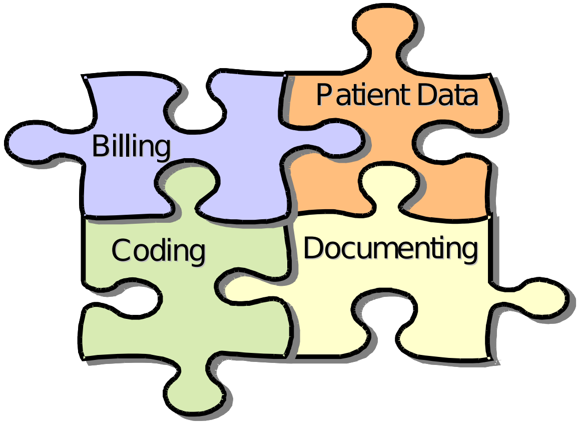
CORE COMPETENCIES

What are RVUs and RWPs?



- Relative Value Units (RVUs)
  - Outpatient Encounters
  - Based on Current Procedure Terminology (CPT) Codes
    - Evaluation and Management (E&M) Codes are CPT Codes
  - ICD Codes do not generate RVUs
  - CPT (including E&M codes) generate “Revenue”
    - Fee of Service Care under PPS
    - Champus Maximum Allowable Charge (CMAC)
      - **CPT code**
      - **CMAC Class**
      - **Geographical Region**
- Relative Weighted Products (RWPs)
  - Inpatient Records
  - Based on Diagnosis Related Group (DRG)

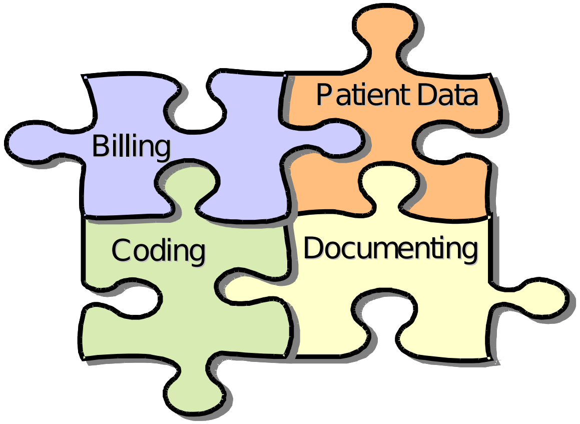
What does the Data say?


Billing
Patient Data
Coding
Documenting

- Workload is down across the Military Health Service (MHS)
- Our coding is showing that we are seeing less acute patients

CORE COMPETENCIES

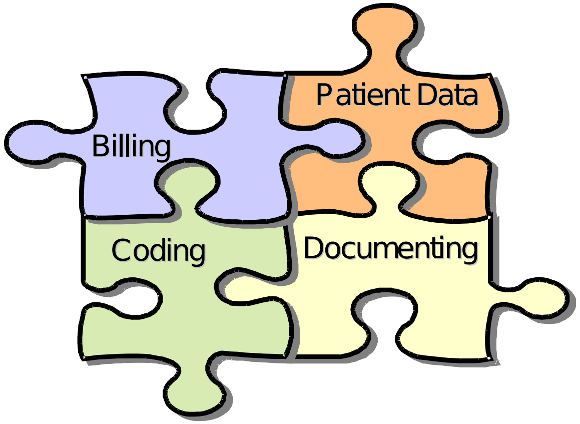
Why is this happening?


Patient Data
Billing
Coding
Documenting

- Ask a provider and the common answers are:
  - The coder is playing it safe…
  - I didn’t learn coding in medical school…
  - The coding training I received was to general…
  - Where is the incentive for me to code?
  - I don’t have enough manpower in my clinic…

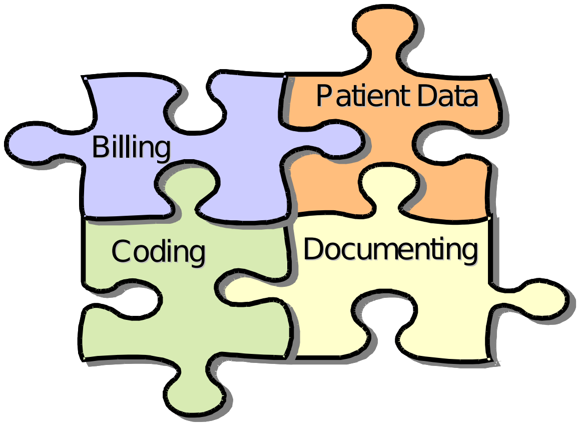
CORE COMPETENCIES

Why is this happening?


Billing
Patient Data
Coding
Documenting

- Ask a coder and the common answers are:
  - The provider is not documenting…
  - CMS rules are…
  - I don’t understand why DoD codes wrong…
  - The provider doesn’t listen to me…
  - How can I make the provider…
  - I don’t have enough time to do my job

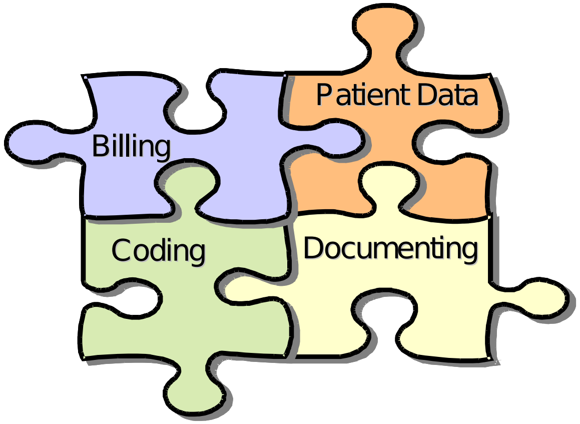
Bridging the Gap



- What is the Truth?
  - Providers need help to document correctly
    - Add to GME Program
    - Training at Provider conferences
    - CHCSII templates will help if set up correctly
  - MTFs need Coders to look for opportunities
    - Providers need positive feedback to improve
    - Provide one-on-one and/or specialty group coding training
    - PRO-Staff meetings
    - Work with GPMs to improve records management
    - Get trained as a CHCSII Super User to help providers, reduce your workload

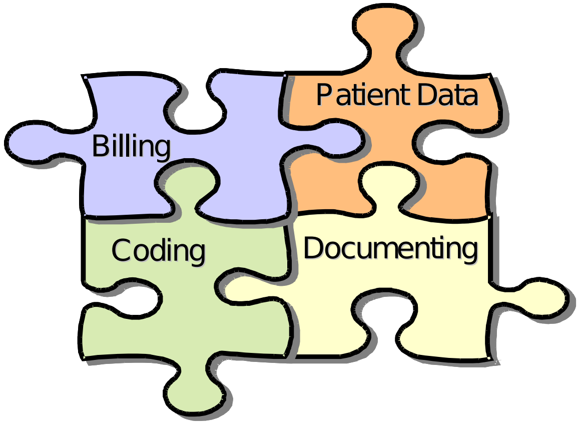
CORE COMPETENCIES

MEPRS link to Coding and Billing



- **MEPRS Code assignment**
  - Recommend MEPRS Program Manager is the only person to assign MEPRS codes
  - Must conform to WAM business rules or workload will not transmit to WWR or EAS IV
- ***Note if you use a MEPRS code that is for Minutes of Service***
  - ***ZERO RVU credit***
  - ***Will not flow to TPOCS – NO BILL PRODUCED***

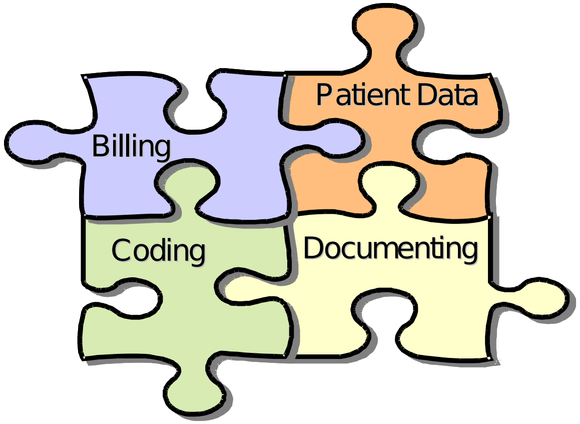
What are we missing?



- Ensure when coding that you are using the correct MEPRS code
  - DG** is for minutes of service
  - Invalid MEPRS codes, e.g. BZZZ, PMTA
- Ensure your providers have the the correct Provider Specialty Code
  - Under the FY06 PPS methodology
    - AF has lost 44K RVUs
    - Army has lost 392K RVUs
    - Navy has lost 344K RVUs

CORE COMPETENCIES

What are we missing?


Patient Data
Billing
Coding
Documenting

- Injections
- Non Lab/Non Rad tests - EKGs, EEGs, EMGs,
- Readiness Related
  - Preventative Health Exams
  - Pre/Post Deployment Exams
- Procedures
- Inpatient Professional Services – Rounds, Procedures
- Care being done by our providers in civilian facilities

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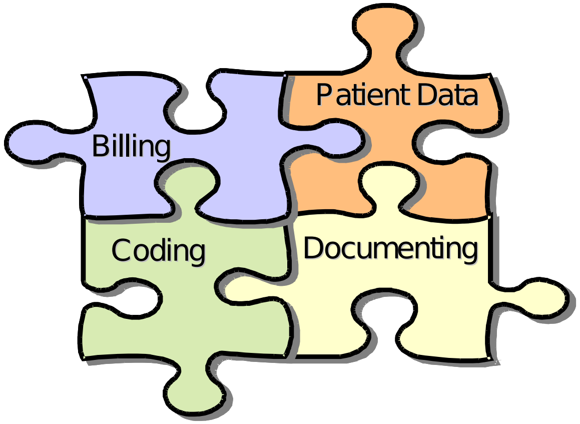
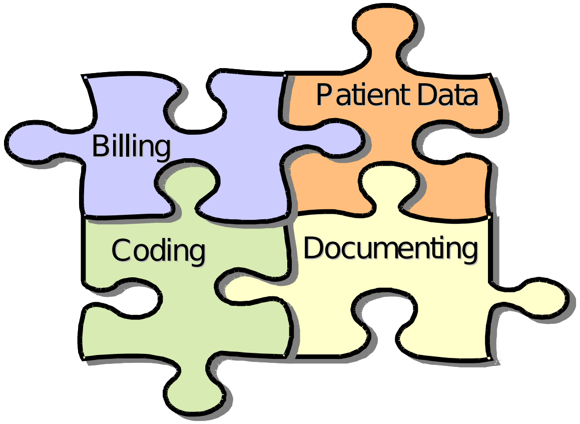
Why?


Billing
Patient Data
Coding
Documenting

- Number 1 Reason:
  - Not understanding who the payer is
- Number 2 Reason:
  - Not accepting that the military is different from the civilian sector in how it delivers health care

CORE COMPETENCIES


Patient Data
Billing
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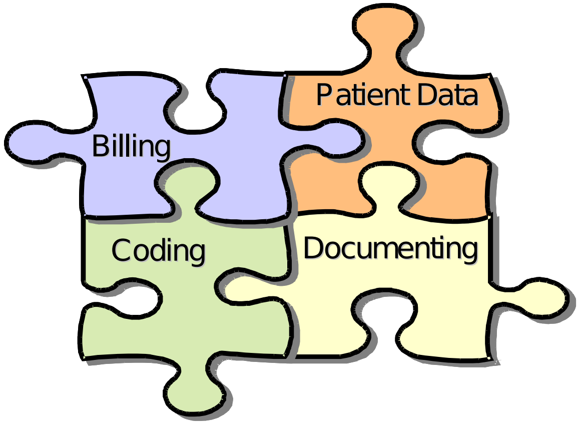
Documenting

Who are our payers?

- Health Affairs (HA)
  - Tricare Management Activity (TMA)
  - $12 Billion Plus Budget in Direct Health Care
- Other Health Insurance Companies
  - Blues, Mail Handlers, etc
- Other Federal Agencies
  - Coast Guard, NOAA, PH, etc

C O R E   C O M P E T E N C I E S

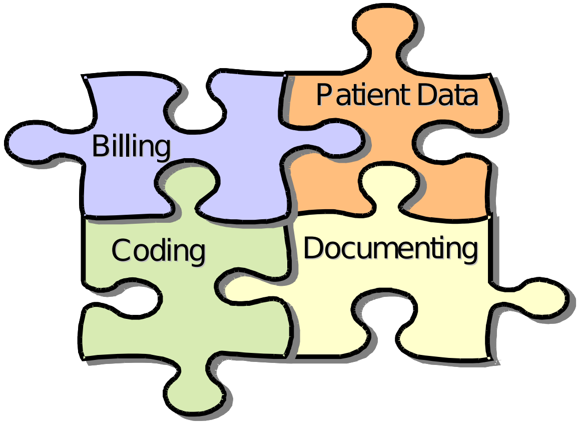
Who are ***not*** our payers?


Patient Data
Billing
Coding
Documenting

- MEDICARE
  - Except for a few MTFs on a limited civilian emergency basis
- Beneficiaries
  - Military Health Care is an Entitlement
  - No Co-Pays in the MTF
  - No Balance Billing of the Patient

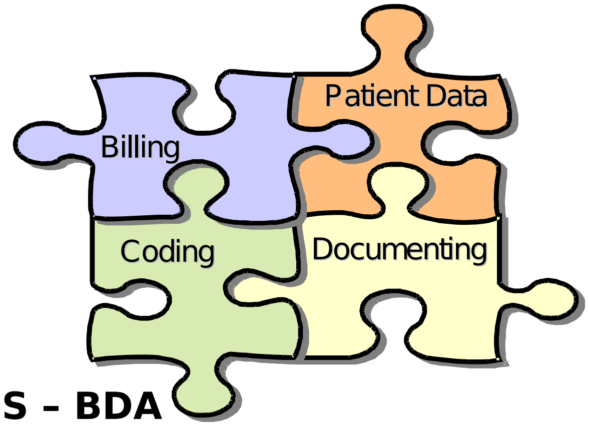
C O R E C O M P E T E N C I E S

How do we bill our main payer?


Billing
Patient Data
Coding
Documenting

- Using the Standard Ambulatory Data Record (SADR)
  - First 4 CPT codes and First E&M code
  - RVUs
- Using the Standard Inpatient Data Record (SIDR)
  - DRG based = RWPs

Value of Care

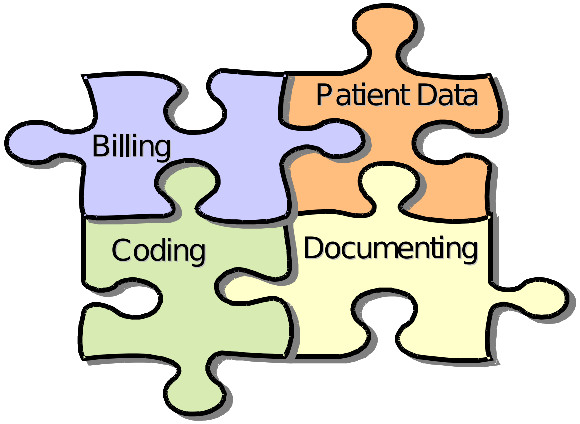


- **PEDIATRICS – BDA**
- **Provider Specialty Code = 040**
  - **Pediatrician**
- **Diagnosis Codes**
  - **204 Lymphoid Leukemia**
  - **112.89 Candidial Endocarditis**
- **Procedure Code**
  - **90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour**
  - **90781 – Each additional hour**
- **E&M Code**
  - **99214 – Level 4 Established Patient**
- **OHI – Yes**
- **CMAC Value = $130.73 Class 1 Provider**
- **Will you bill for this patient? Yes**
  - **Reimbursement - $130.73**
- **PPS RVU = 1.44 Reimbursement = $106.56**

- **PEDIATRICS – BDA**
- **Provider Specialty Code = 949**
  - **Pediatrics**
- **Diagnosis Codes**
  - **204 Lymphoid Leukemia**
  - **112.89 Candidial Endocarditis**
- **Procedure Code**
  - **90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour**
  - **90781 – Each additional hour**
- **E&M Code**
  - **99214 – Level 4 Established Patient**
- **OHI – Yes**
- **CMAC Value = UNKNOWN**
- **Will you bill for this patient? NO**
  - **Reimbursement $0**
- **PPS RVU/Reimbursement = *ZERO!!!!!***

CORE COMPETENCIES

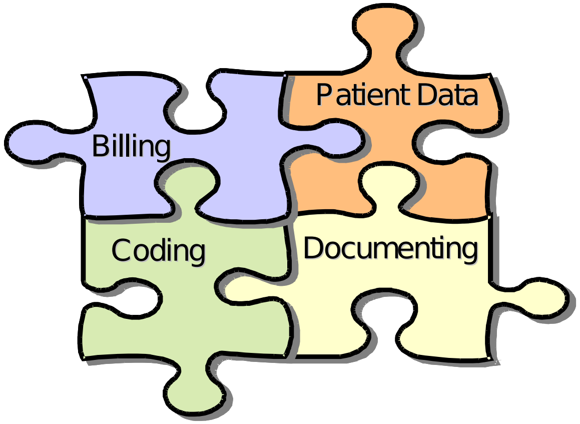
Military Health System Mission!


Patient Data
Billing
Coding
Documenting

- Provide Medical Care to our Beneficiary Population – Over 8.5 Million
- Operate in a Peaceful and Hostile Environments
  - In Over 100 countries
- JOB #1 -- Support the Combat Troop
  - On Land
  - At Sea
  - In the Air

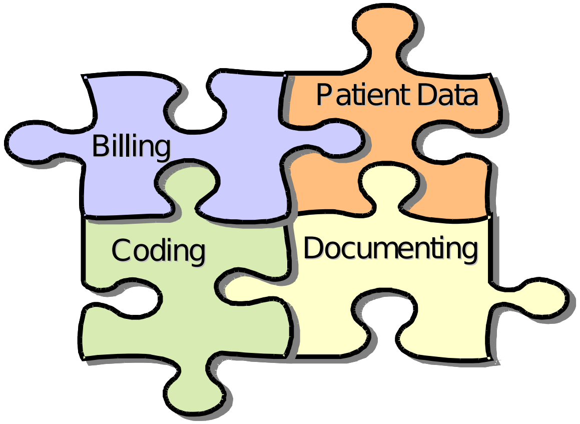
CORE COMPETENCIES

We’re Special


Patient Data
Billing
Coding
Documenting

- Entitled to Health Care
- Preventative Health Exams
- Pre/Post Deployment Exams
- Special Military People – Flyers, Submariners, Special Forces
- Non American Military Members
- Prisoners of War/Detainees
- Humanitarian Missions

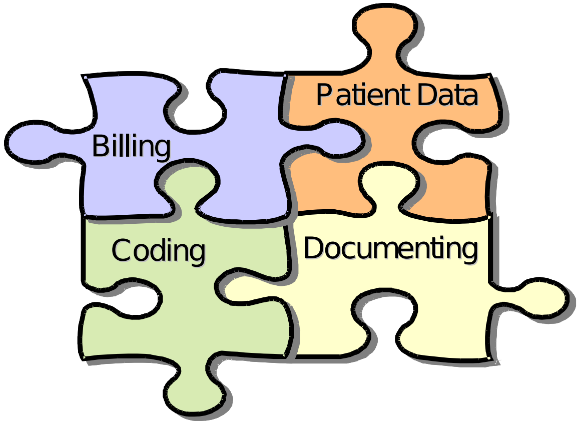
CORE COMPETENCIES


Billing
Patient Data
Coding
Documenting

Completeness and accuracy of coding becomes paramount

Bad Code = Poor Payment

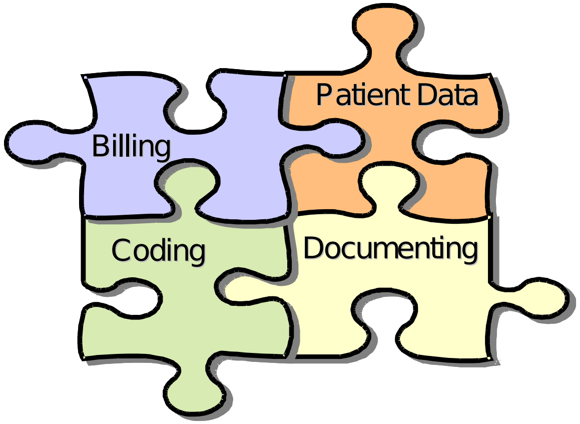
CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

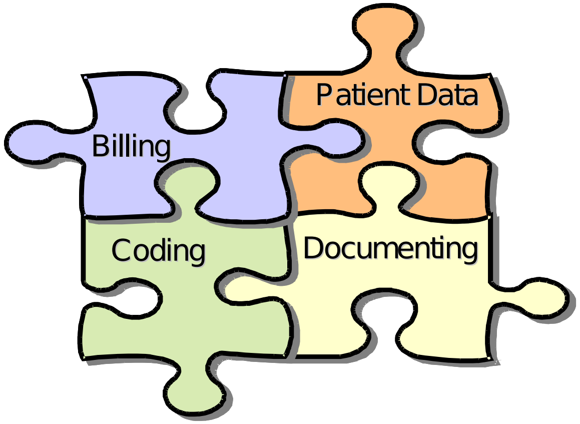
No such thing as:

“It’s not my job”

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

CORE COMPETENCIES

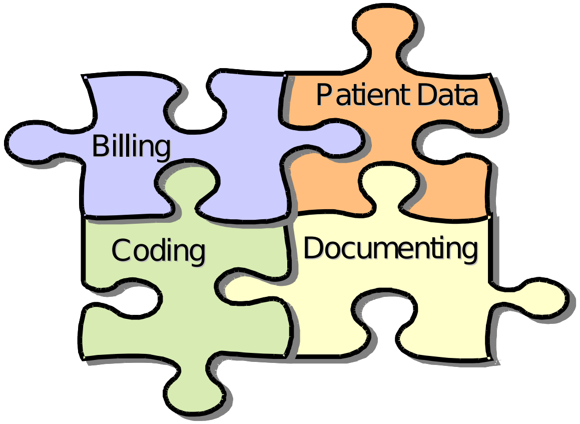

Patient Data
Billing
Coding
Documenting

GME and the Military Health System

Lesvia O Millican, CPC, PMCC
Wednesday, 18th 2005
Track 2, UBU

CORE COMPETENCIES

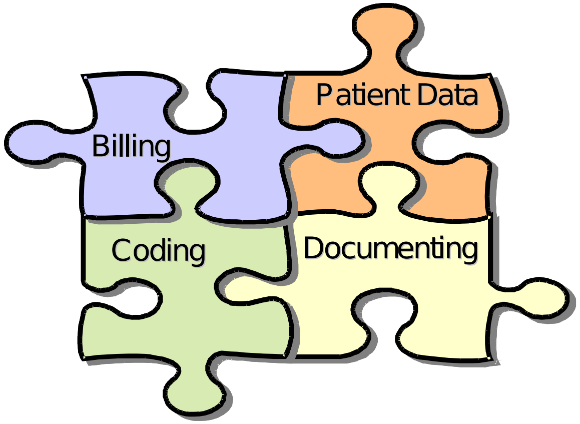
Objectives


Patient Data
Billing
Coding
Documenting

- Guidelines
- Documentation
- Procedures
- Workload
- CHCS-II
- Primary Care Exception

CORE COMPETENCIES

CMS Guidelines



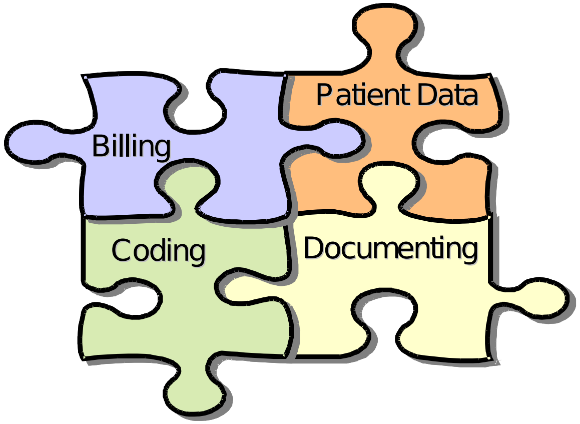
- **For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:**

  a. That they performed the service or were physically present during the key or
  critical portions of the service when performed by the resident; and
  b. The participation of the teaching physician in the management of the patient.

- When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.
- Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.
- On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

CORE COMPETENCIES

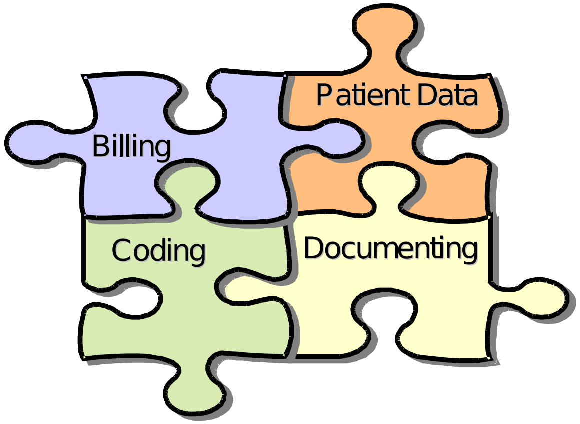
CMS Guidelines



- CMS, Transmital 1780, Section 15016:
 Date: November 22, 2002

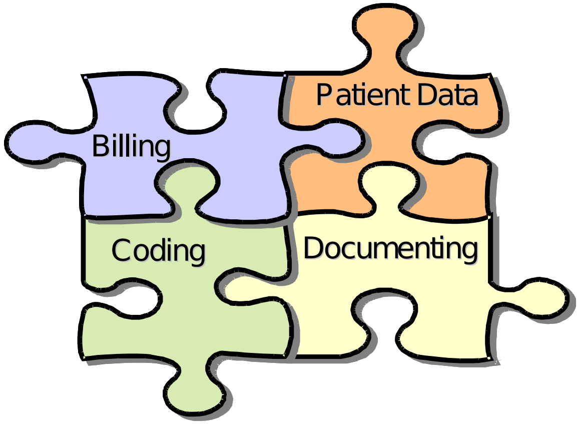
 Supervising Physicians in Teaching Settings, is revised to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues and update regulatory references.

Definitions



- **Resident:** An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of “resident”.

- **Medical Student:** An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident.

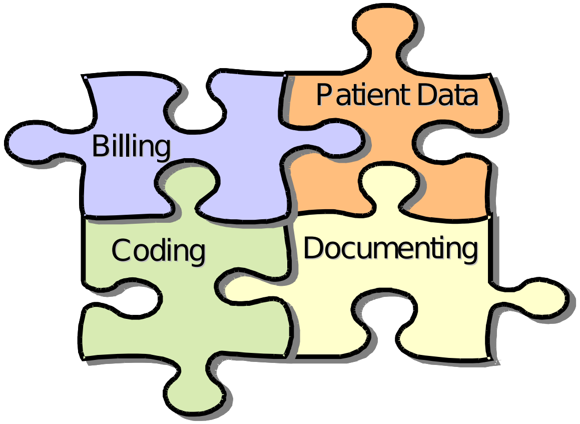


Definitions cont'd

- **Teaching physician:** A physician (other than another resident) who involves residents in the care of his or her patients.
- **Direct medical and surgical services:** Services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital.

CORE COMPETENCIES

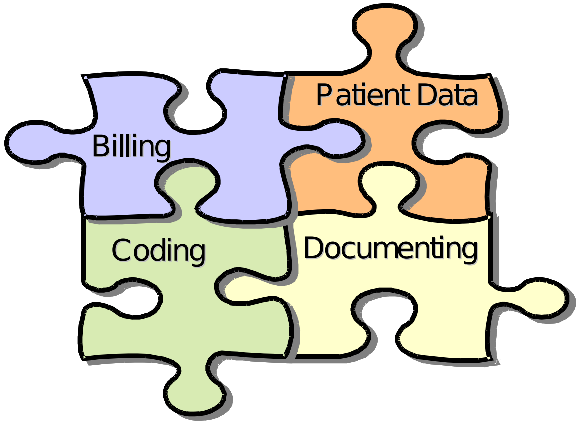
Definitions cont’d



- **Teaching Hospital:** A hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

- **Teaching Setting:** Any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology.

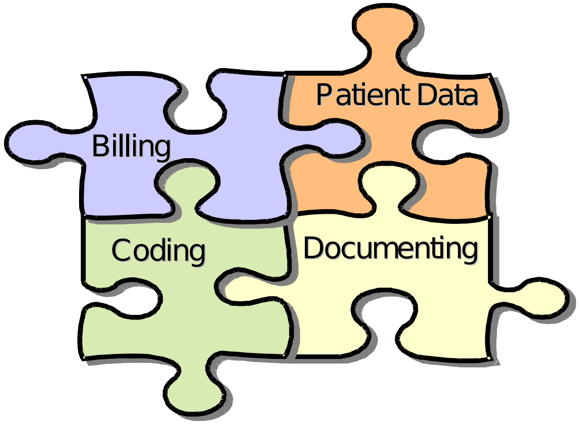
Definitions cont'd



- **Critical or Key Portion:** Part (or parts) of a service that the teaching physician determines is (are) a critical or key portion (s). For purposes of this section, these terms are interchangeable.
- **Documentation:** Notes recorded in the patient's medical records by a resident, and/or teaching physician or others regarding the service furnished.
  - Documentation may be dictated and typed, hand-written or *computer-generated*, and typed or handwritten.

C O R E

C O M P E T E N C I E S

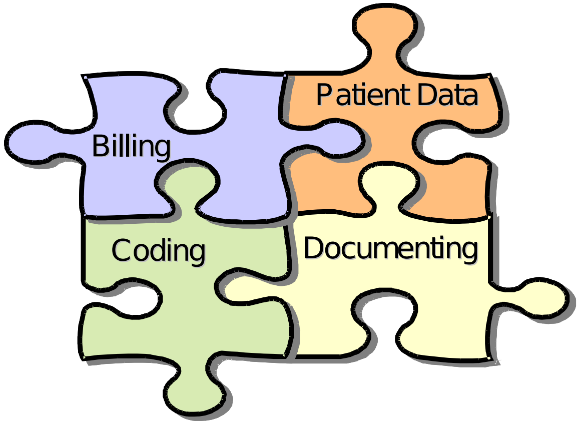

Patient Data
Billing
Coding
Documenting

Definitions cont'd

- **Physically Present:** The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

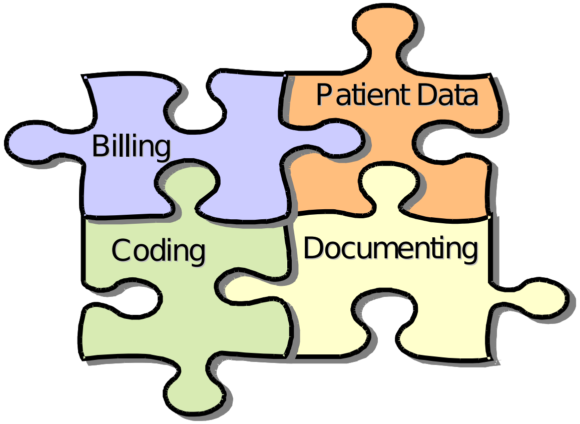
CORE COMPETENCIES

Importance of Documentation


Billing
Patient Data
Coding
Documenting

- **The medical record facilitates:**
  - Evaluation, treatment & monitoring
  - Communication and continuity of care
  - Accurate & timely claims review and quality of care
  - Collection of data for research and teaching

Medical Record Documentation



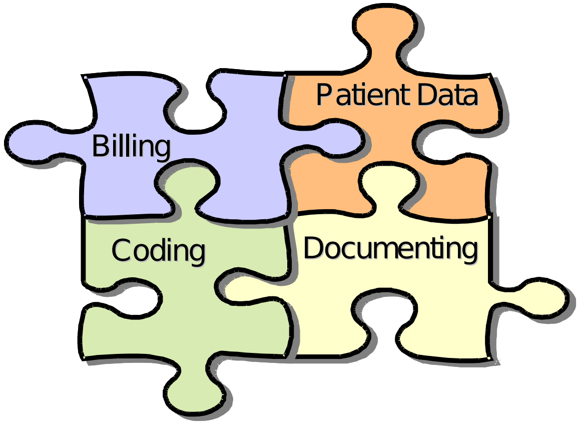
The medical record is a legal record of care and

should:

- Be complete and legible
- Include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan of care
  - Date and legible identification of the observer

CORE COMPETENCIES

Medical Record Documentation cont’d



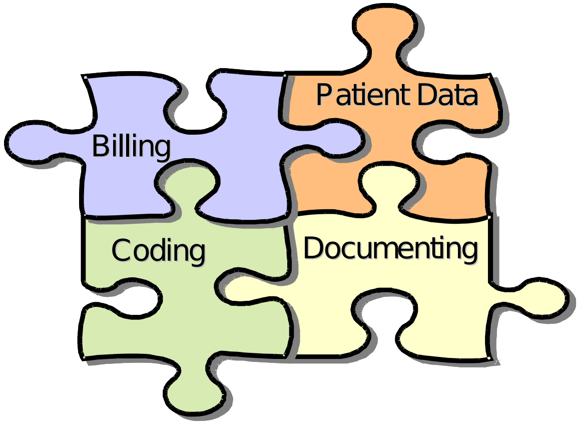
The medical record should:

– Include (cont’d)
  - Rationale for ordering diagnostic and other ancillary services
  - Past and present diagnosis
  - Appropriate health risk factors
  - The patient’s progress, response to and change in treatment, and revision of diagnosis

– Support CPT & ICD-9-CM codes reported for claims or data capture

CORE COMPETENCIES

Evaluation and Management Service


Billing
Patient Data
Coding
Documenting

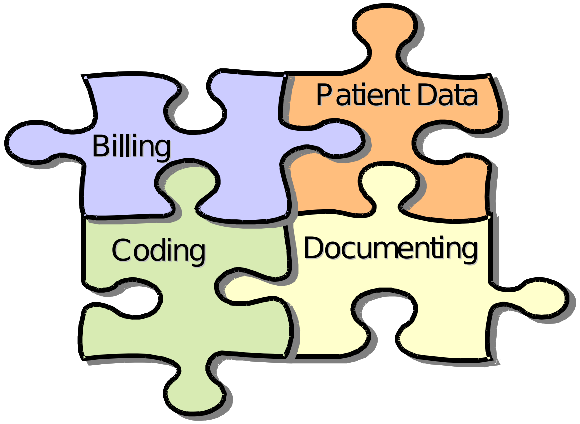
99201-99205 New Patient

Requires all three key components

- History
- Exam
- Medical decision making

- **Teaching physician must be present for the key or critical portions of the exam**

Evaluation and Management Service


Patient Data
Billing
Coding
Documenting

99211-99215 Established Patient

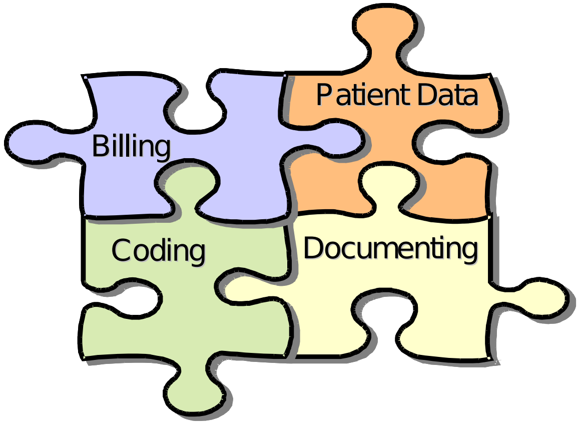
Requires two out of three key components

- History
- Exam
- Medical Decision Making

- **Teaching physician must be present for the key or critical portions of the exam**

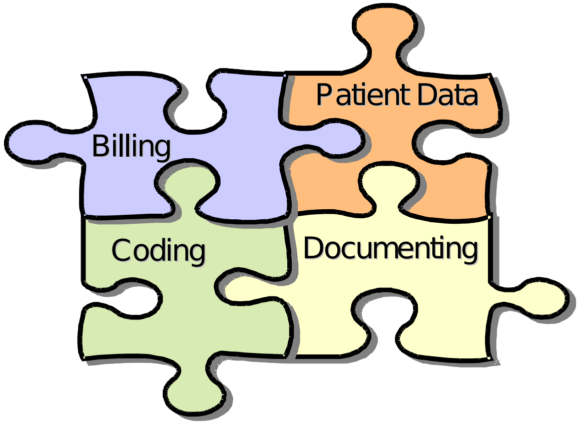
CORE COMPETENCIES

Components of E&M Services


Patient Data
Billing
Coding
Documenting

- **Key Components**
  - History
  - Examination
  - Medical decision making
- **Contributory Components**
  - Counseling
  - Coordination of care
  - Nature of presenting illness
  - Time

Consultation vs. Referral



Consultation

- A request for advise or an opinion
- Suspected problem or condition
- Undetermined course of treatment
- The consulting physician must submit a written report of findings and suggestions to the requesting physician
- Use consultation codes

Example: “ Request from Dr. Smith, please evaluate and give recommendations for treatment plans.”

Referral

- A transfer of all or portion of the patients care
- Diagnosed problem or condition
- Prescribed/known course of treatment
- The patient is referred to a specialist
- No written letter or request is required
- Use new/established patient codes

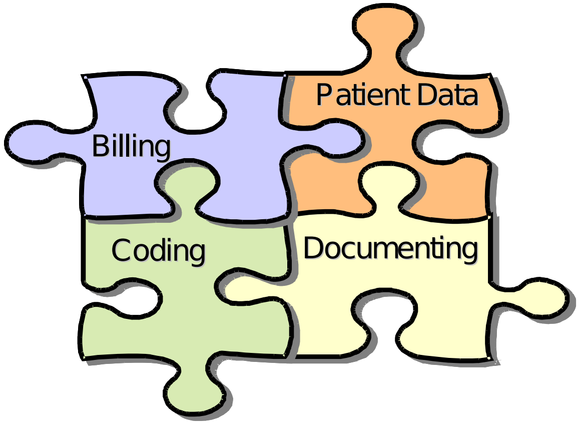
Example: “Referral from Dr. Smith please,

please manage/treat for this illness,

disease or condition.”

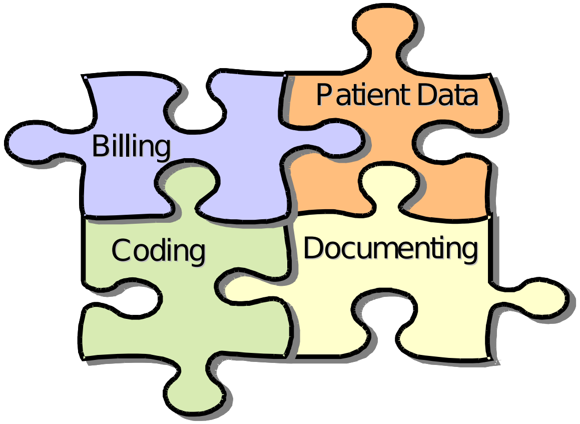
CORE COMPETENCIES

Time



- Time may be the key or controlling factor to qualify the use of a particular E&M service provided certain conditions have been met. Necessary criteria:
  - 50% or more of the visit must be spent in counseling or coordination of care
  - Applies to physician services only
  - Must be face-to-face time
  - Documentation supports reason for counseling
  - Documentation of total visit time and time spent in counseling or coordination of care

Documentation



- **Example: Resident**

  Alice 45 y/o established pt presents for routine f/u visit.

  Patient complains of headache and rhinitis.

  History: Problem with allergies during Spring for years, mild sinus drainage, clear nasal discharge.

  Review of Systems:

  Allergic/immunologic: Seasonal allergic reactions to mold

  Exam:

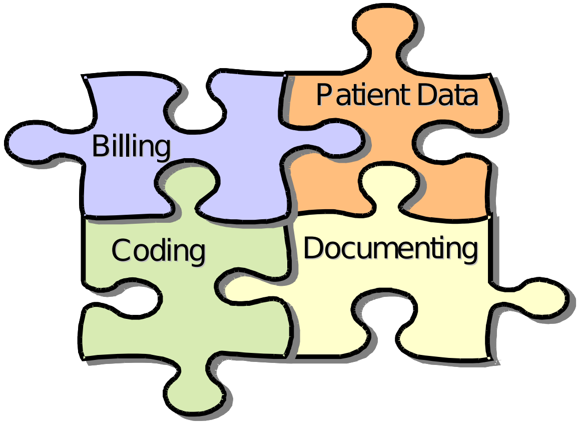
  Eyes: clear no drainage, discharge
  Nasal: mild drainage
  Skin: no rashes
  Breast: normal, no lumps

  Medical Decision Making:

  prescription for allegra, follow up as needed.

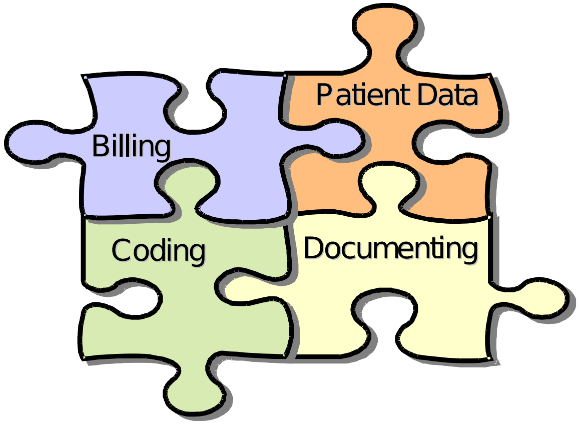
  Diagnosis: Allergic Rhinitis

Documentation



- **Example:** **Teaching Physician**
  Alice 45 y/o established pt presents for routine f/u visit.
  Patient complains of headache and rhinitis.
  History: Problem with allergies during Spring for years, mild sinus drainage, clear nasal discharge.
  Review of Systems:
  Allergic/immunologic: Seasonal allergic reactions to mold
  Exam:
  Eyes: clear no drainage, discharge
  Nasal: mild drainage
  Skin: no rashes
  Breast: normal, no lumps
  Medical Decision Making:
  prescription for allegra, follow up as needed.
  Diagnosis: Allergic Rhinitis

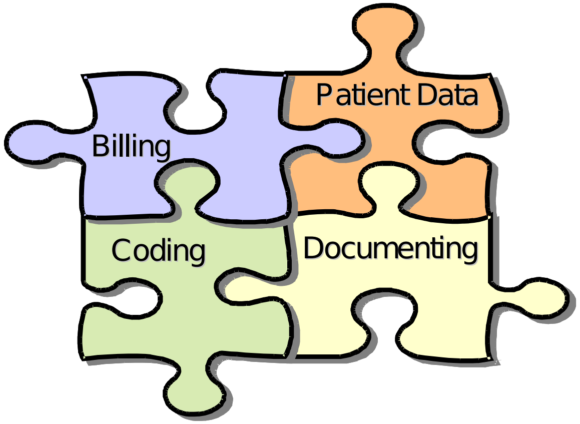
Documentation provided by students



- Student documentation:
  - The documentation of an E/M service by a student that may be referred to by the teaching physician is limited to the review of systems and/or past family/social history.
  - The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note.
  - If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service.

CORE COMPETENCIES

Document Statement



- **Initial or Follow-up Visit**

  Example:

  “I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident’s note.”

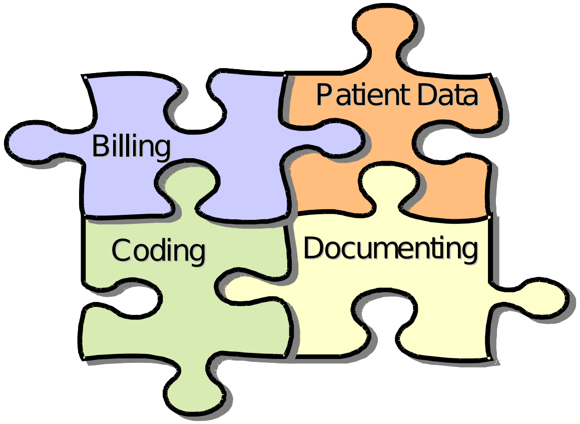
- **Follow-up Visit**

  Example:

  “I saw the patient with the resident and agree with the resident’s findings and plan.”

CORE COMPETENCIES

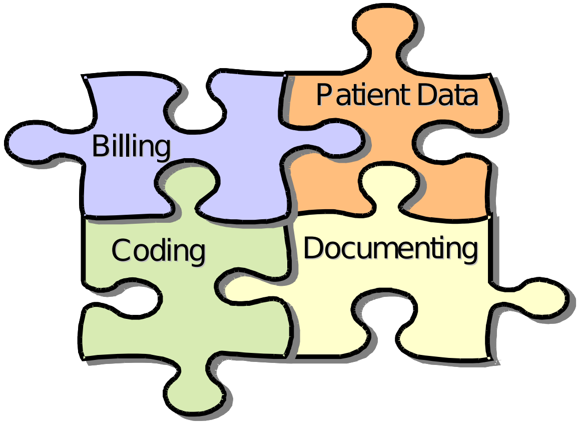
Document Statement



- **Following are examples of unacceptable documentation:**
- “Agree with above.”, followed by legible countersignature or identity.
- “Rounded, Reviewed, Agree.”, followed by legible countersignature or identity.
- “Discussed with resident. Agree.”, followed by legible countersignature or identity;
- “Seen and agree.”, followed by legible countersignature or identity.
- “Patient seen and evaluated.”, followed by legible countersignature or identity.

C O R E C O M P E T E N C I E S

Document Statement

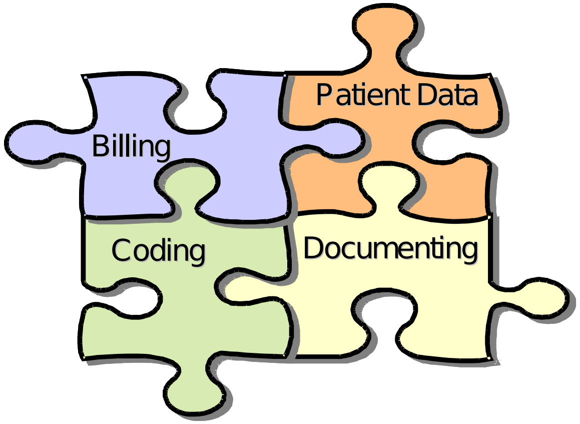


A legible countersignature or identity alone.

- Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

CORE COMPETENCIES

Document Statement



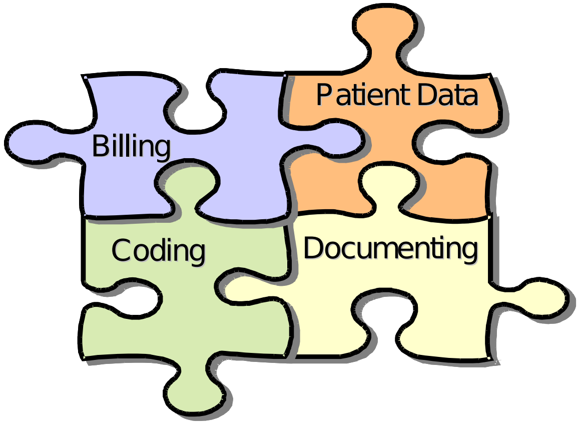
- **Suggested templates:**

"Case discussed with Dr. Resident at time of visit. Patient presents a diagnosis of_________ and treatment with________ with________. Agree/Revise with diagnosis of ________ and plan of care to_______."

OR

"Patient case reviewd and discussed with resident at the time of visit. Given history of_________ Exam and assessment show_____________,(state test findings of significance). I agree/revise plan of care as_________."

Inpatient Documentation



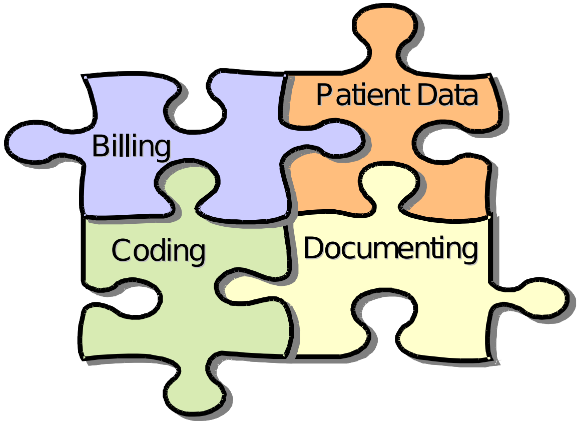
Examples of minimally acceptable documentation

- **Admitting Note:** “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”
- **Follow-up Visit:** “Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.”
- **Follow-up Visit:** “Hospital Day #5. I saw and examined the patient. I agree with the resident’s note except the heart murmur is louder, so I will obtain an echo to evaluate.”

(**NOTE: I**f there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

CORE COMPETENCIES

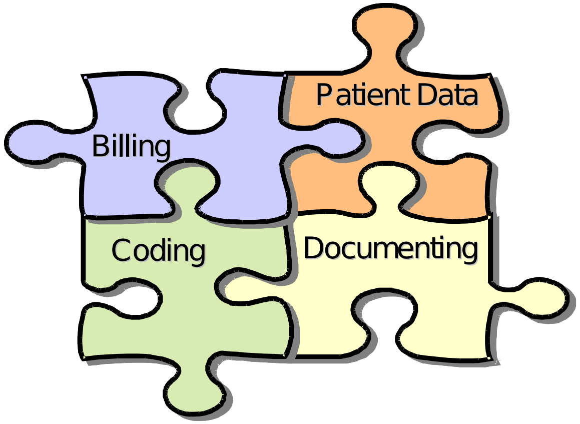
Inpatient Documentation cont'd



- **Documentation:** Notes recorded in the patient's medical records by a resident, and/or teaching physician or others. Documentation may be dictated and typed, hand-written or *computer-generated*, and typed or handwritten.
  - Documentation must be dated and include a legible signature or identity. The documentation must identify the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

CORE COMPETENCIES

Inpatient Documentation cont’d

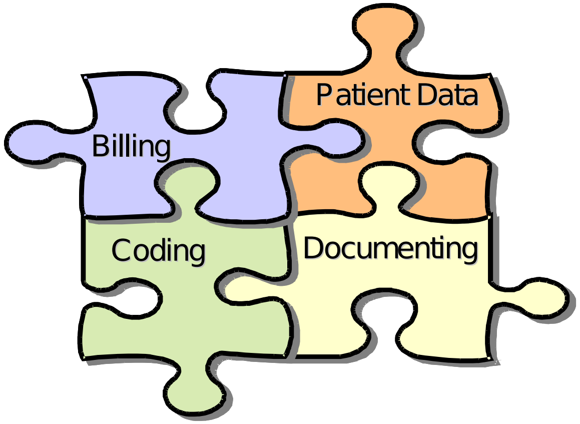


- Hospital Inpatient Services:
  - 99221-99223
    - History
    - Exam
    - Medical decision making
- Subsequent Hospital Care:
  - 99231-99233
    - History
    - Exam
    - Medical decision making

- Observation or Inpatient Services:
  - 99234-99236
    - History
    - Exam
    - Medical decision making
- Hospital Discharge Services:
  - 99231- Discharge-30 mins or less
  - 99239-Discarege- more tht30 mins.

CORE COMPETENCIES

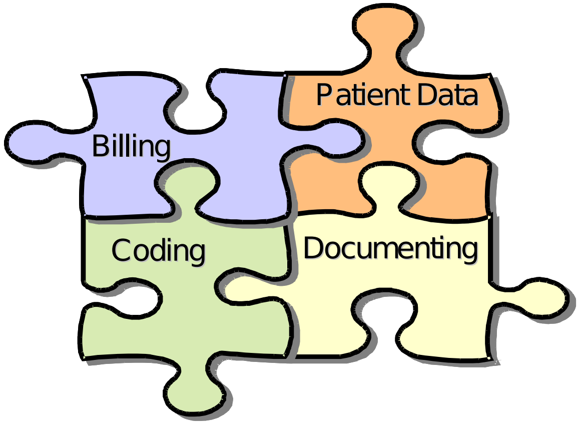
Documentation of TP Presence & Signature Requirements



- **Countersignature or identity alone**
  - Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

CORE COMPETENCIES

MHS Guidelines

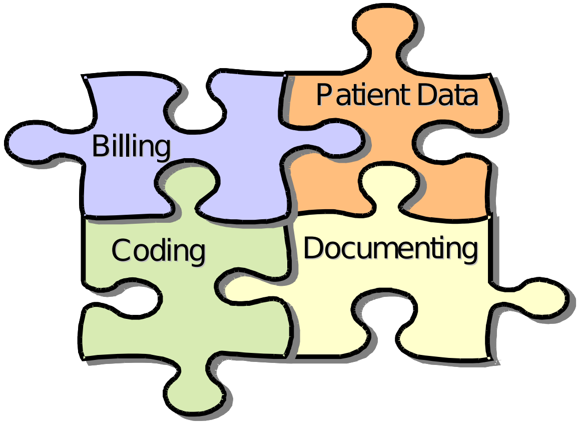

Billing
Patient Data
Coding
Documenting

- TMA Memorandum for SG’s
  - Army SG
  - Navy SG
  - AF SG

Document signed and dated Feb 28 2002

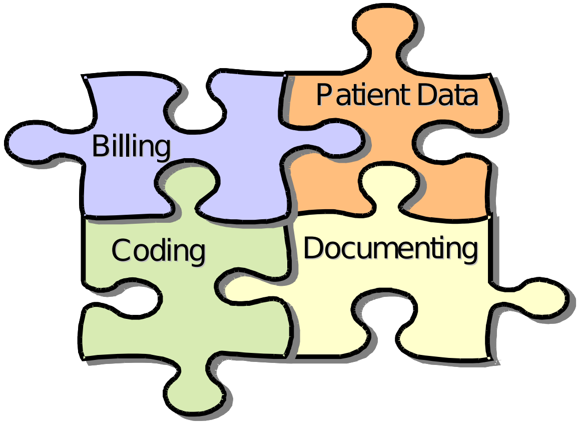
CORE COMPETENCIES

MHS Guidelines



- **Guidelines for Billing Resident Services in Teaching Hospitals**
  - Physician services may be billed if:
    - Services are provided by a physician who is not a resident.
    - Services are furnished jointly by the teaching physician and Resident who requires teaching physician presence.

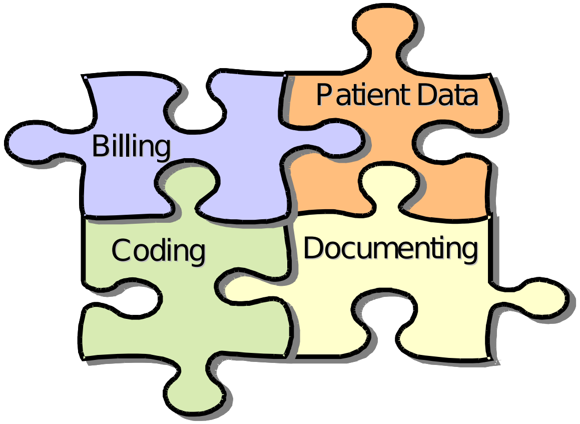
MHS Guidelines cont’d



- Services furnished jointly by a teaching physician require:
  - Both resident and the teaching physician are entered in ADM for that encounter.
  - Resident is listed as Primary and the teaching physician as secondary.
  - Documentation MUST comply with Coding and Documentation Guidelines for MHS.

CORE COMPETENCIES

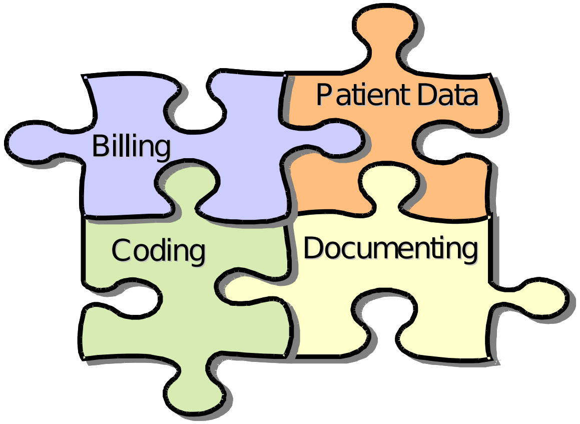
MHS Guidelines cont’d



- Coding and Documentation:
  - E&M Service
    - Teaching physician must be physically present during the key portion of the service in accordance with facility GME program.
    - Teaching Physician does not need to be present for follow-up visits for established patients.
    - Facilities must follow facility GME policy regarding documentation and review.

CORE COMPETENCIES

MHS Guidelines cont’d



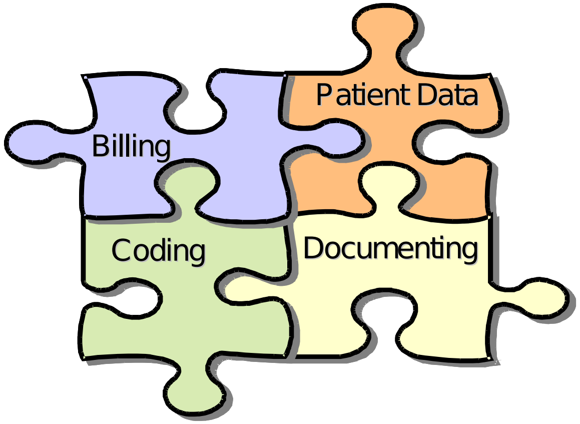
- **Exception:**

  For GME programs in which the residents’ level of training has progressed the where they are capable of providing services without the presence or review of a teaching physician, resident services can be billed with the Lowest and mid level service

New Patient	Established patient
99201	99211
99202	99212
99203	99213

CORE COMPETENCIES

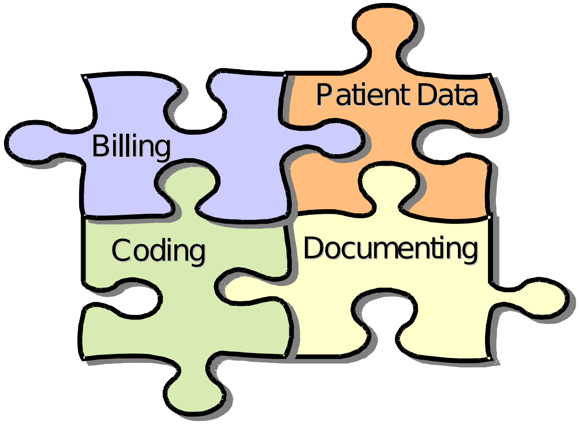
MHS Guidelines cont’d



- **Compliance:**
  - Audit mechanism must be in place to ensure coding and documentation requirements are met.
  - IF a resident is required to have direct supervision, resident will be listed first, staff will be listed second.
  - If the resident meets the criteria to provide care without direct supervision, resident will be listed as primary.

This falls directly in line with DoD I 6040.40 section 5.2.1 and 5.2.1.2.1

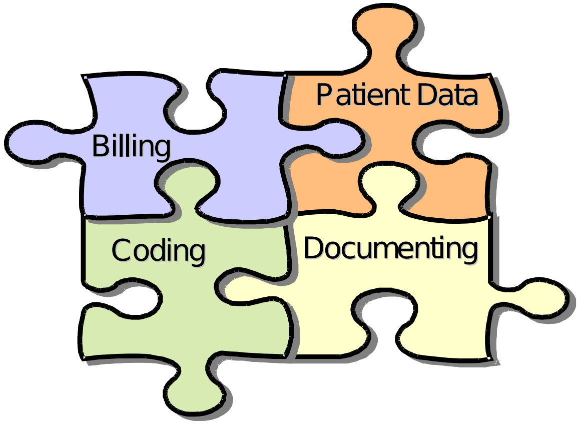
Disconnect CMS vs. MHS



- DoD guidance directs us to code and bill as if we have a primary care exception.
- DoD guidance directs us to follow GME Coding and Documentation Guidelines.
- MHS does not have a Primary Care Exception
- DoD guidance directs to list Resident as Primary and Staff as secondary.
- Residents HIPAA taxonomy codes filter out residents from flowing to TPOCS.
- DoD is unable to bill without a manual process in place.

CORE COMPETENCIES

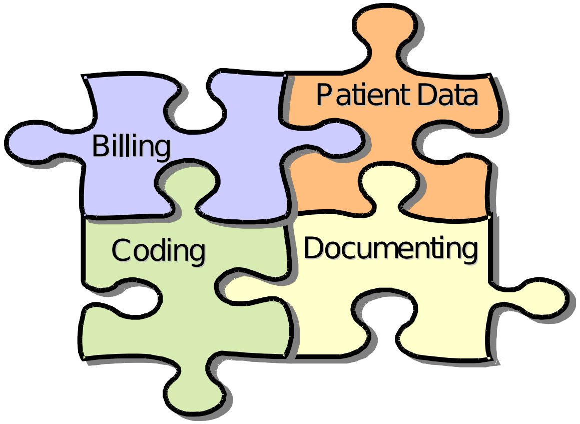
Procedures


Billing
Patient Data
Coding
Documenting

- **Minor Procedures**
  - – For procedures that take 5 minutes or less to complete, e.g., simple suture, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

CORE COMPETENCIES

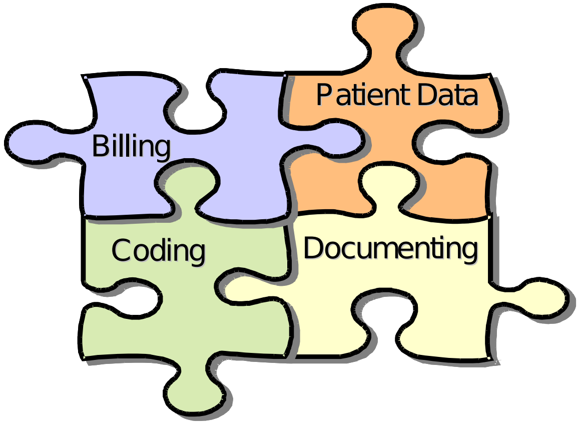
Procedures


Billing
Patient Data
Coding
Documenting

- **Endoscopy Procedures**
  - – Endoscopic procedures (excluding endoscopic surgery that follows the surgery policy) the teaching physician must be present during the entire viewing.

CORE COMPETENCIES

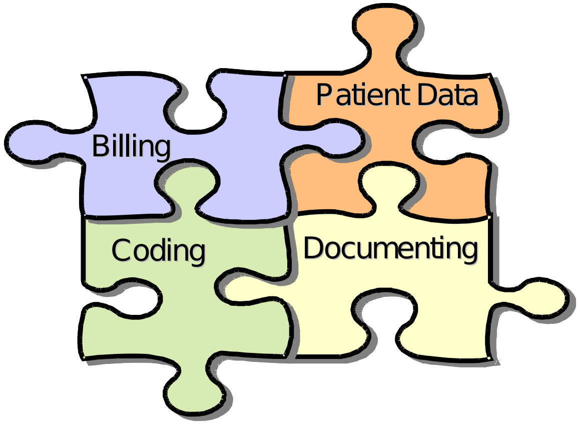
Procedures



- **Complex-Surgeries**
  - **Procedures** - In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.
  - **Surgery (Including Endoscopic Operations)** -. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. *The teaching surgeon determines which post-operative visits are considered key or critical and require his or her presence.*

CORE COMPETENCIES

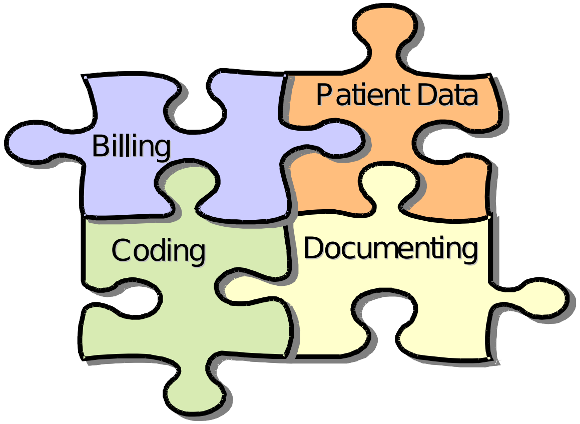
Anesthesia



- **Anesthesia** -
  - **Teaching anesthesiologist** - Involved in a single procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure, Code w/ modifier GC
  - **Teaching physician's physical presence** - Involved during only the preoperative or postoperative visits with the patient is not sufficient. Teaching anesthesiologist - Involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, Code w/ modifier AD - services as medical direction.
  - **Resident w/out theaching physicina physical presence** Code w/ modifier GE (only under PC Exception)

CORE COMPETENCIES

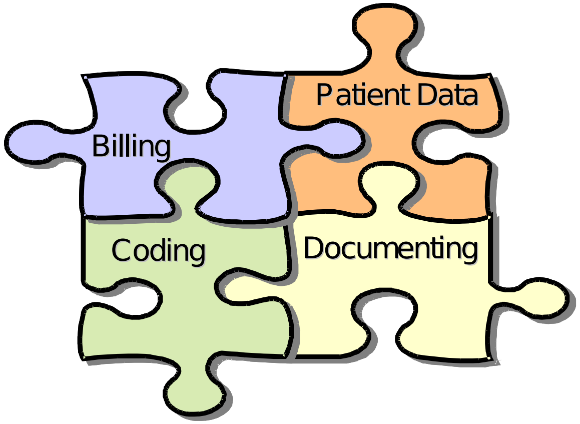
Read and Interpretation



- Interpretation of Diagnostic Radiology and Other Diagnostic Tests.
  - The interpretation is performed by or reviewed with a teaching physician.
  - If the teaching physician’s signature is the only signature on the interpretation, for payment purposes it indicates that he or she personally performed the interpretation.
  - If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident’s interpretation and either agrees with it or edits the findings.

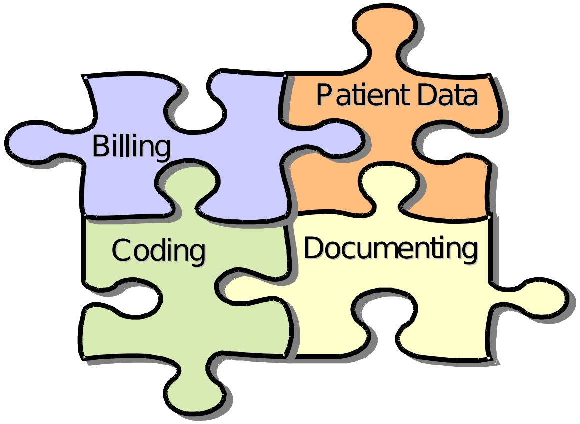
CORE COMPETENCIES

Mental Health



- **Psychiatry**.–
  - For certain psychiatric services, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service through the use of a one-way mirror or video equipment.
  - Time-Based Codes.--For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made.
    - For example: A code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes.
  - Examples of codes falling into this category include:
    - Individual medical psychotherapy (CPT codes 90804- 90829);

Other Evaluation and Management Service

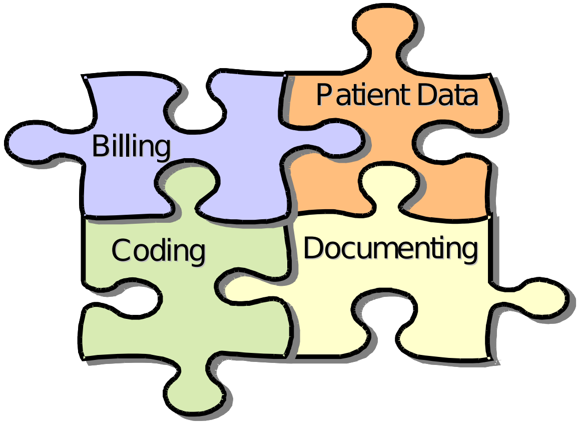


- **Time-Based Codes**
  - Individual medical psychotherapy (CPT codes 90804-90829);
  - Critical care services (CPT codes 99291-99292)
  - Hospital discharge services (CPT codes 99238-99239)
  - E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service:
    - Prolonged services (CPT codes 99358-99359)
    - Care plan oversight (HCPCS codes G0181 - G0182).

Note: **DO NOT** report time for resident spent w/o the presence of the teaching physician.

CORE COMPETENCIES

CHCS II



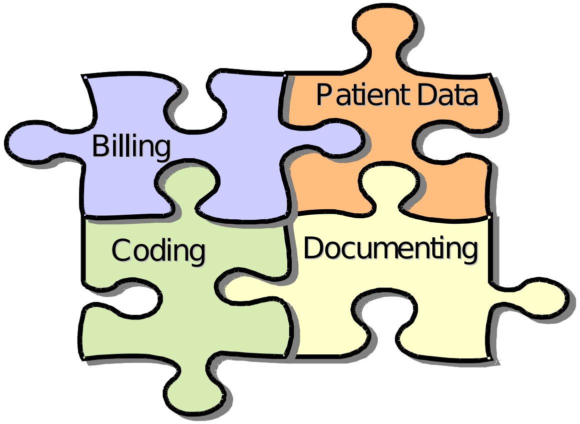
- **Documentation**

  Notes recorded in the patient’s medical records by a resident, and/or teaching physician regarding the service furnished.

  - Documentation may be dictated and typed, hand-written or *computer-generated.*
  - Documentation must be dated and include a legible signature or identity.
  - The documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service and whether the teaching physician was physically present.

CORE COMPETENCIES

Primary Care Exception

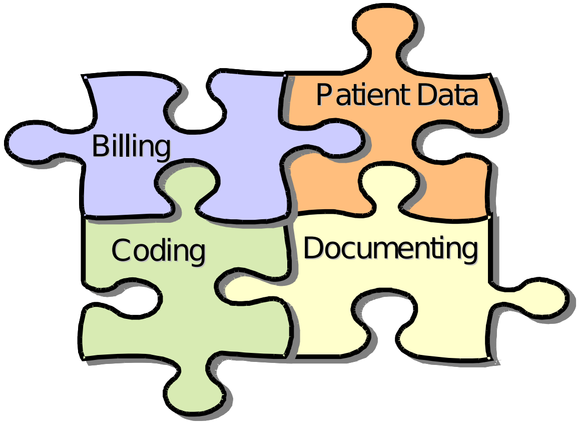


- Exception for E/M Services Furnished in Certain Primary Care Centers
  - Teaching physicians providing E/M services with a GME program granted a primary care exception may bill for lower and mid-level E/M services provided by residents.
  - For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient:	Established Patient :
99201	99211
99202	99212
99203	99213

CORE COMPETENCIES

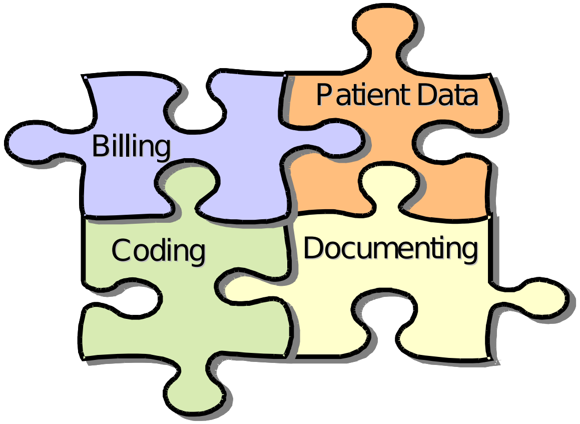
Primary Care Exception



- Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.
- Residency programs most likely qualifying for this exception include:
  - family practice
  - general internal medicine
  - geriatric medicine
  - pediatrics
  - obstetrics/gynecology.
- Certain GME programs in psychiatry may qualify in special situations.

CORE COMPETENCIES

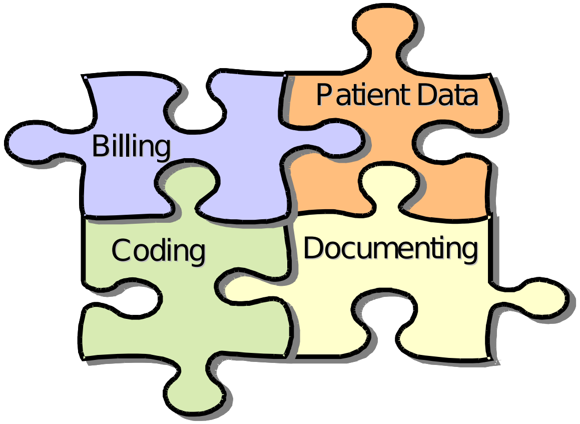
Exception?? Exemption??



- What do these mean?
  - Exception: Means that a facility has requested and is recognized as having put in place a compliance plan that ensures supervision of residents and is allowed to bill for Resident care.(99201-99203/99213-99215)
  - Exemption: Means that the facility is exempt from following the teaching physician guidelines set forth by MDCR as they do not bill MDCR for Resident Care.

CORE COMPETENCIES

VA- Primary Care “Exemption”

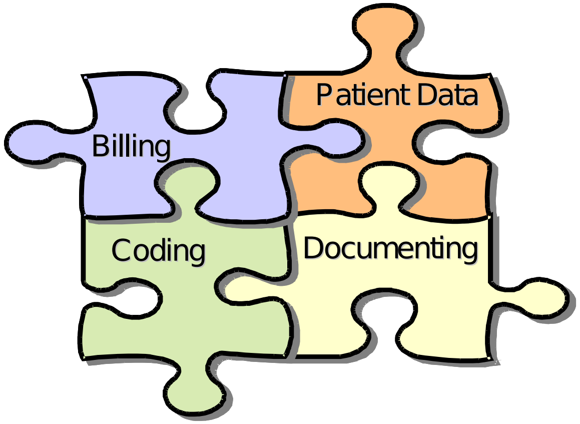


- What do we know about the VA “Exemption”
  - They do not bill Medicare so therefore they are exempt from their teaching physician requirements
  - They must still follow the rules and guidelines set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Accreditation Council for Graduate Medical Education (ACGME) requirements.
  - A licensed and independent practitioner must still supervise and be responsible for all resident delivered care.

CORE

COMPETENCIES

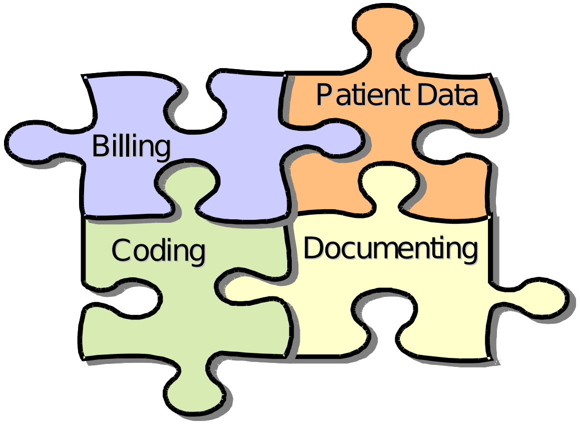
VA- Primary Care “Exemption”



- Like the VA, we should ensure that we follow the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).
- VA and CME documents emphasize providing residents with direct experience in progressive responsibility for patient management in an environment that ensures involvement of the supervising practitioner in each type of resident-patient encounter.

CORE COMPETENCIES

MHS Compliance Problems cont’d



Compliance

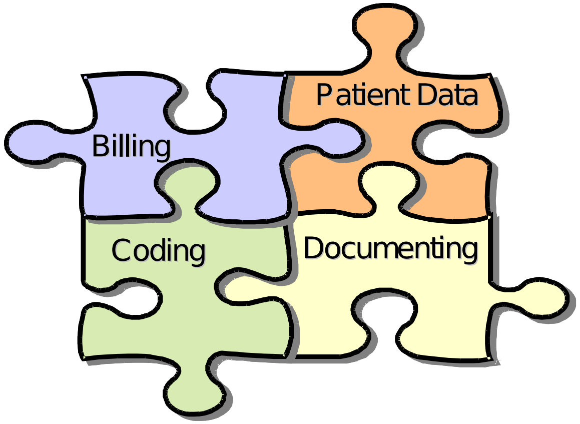
- **Actions 1:**
  - Claims submitted to insurance carriers for care provided by residents in a properly supervised environment must identify the supervising practitioner's name and credentials.
  - Modifier “GC” needs to be attached to each procedure code in order to distinguish care provided by a resident under the direction of a teaching physician.

***NOTE:** The modifier “GC” is defined as "This service has been performed in part by a resident under the direction of a teaching physician."*

NOTE: Systems limitations prevent modifiers from flowing

CORE COMPETENCIES

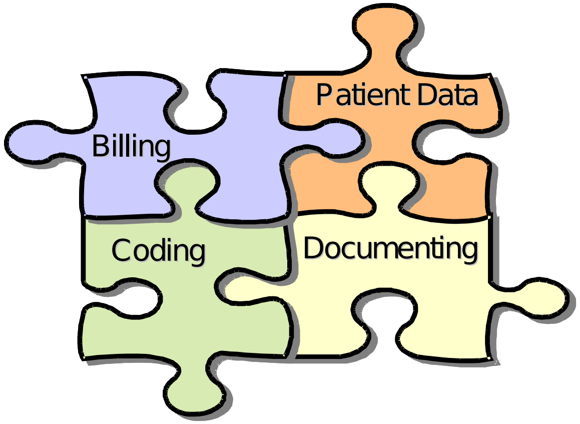
MHS Compliance Problems cont’d



- **Action 2:**
  - MHS staff members accurately reflect health care services delivered by:
    - Applying the appropriate codes as supported by medical record documentation.
    - Identifying the person who provided care.
    - MHS staff members institute procedures to ensure compliance with insurance industry standards, as applicable.
    - All residents, supervising practitioners, other health care providers, and administrative personnel are aware of the billing policy.

CORE COMPETENCIES

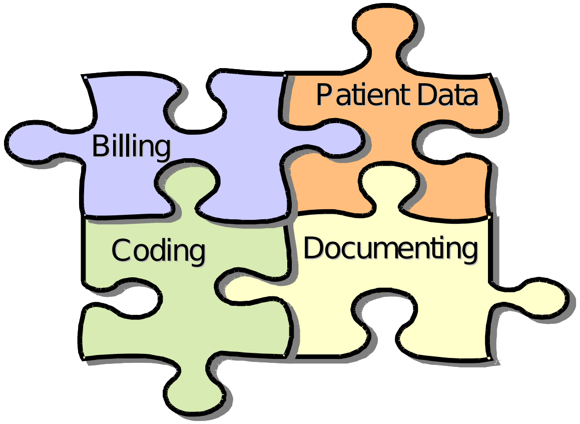
MHS Compliance Problems cont’d



- Since the Military Health System (MHS) has been submitting claims to third-party insurers for professional fees, there has been a discrepancy between the billing requirements for physician services and the requirements for documenting resident supervision for educational purposes.
- MHS is currently pursuing the same exemption that was allowed for the VA in order to become compliant.

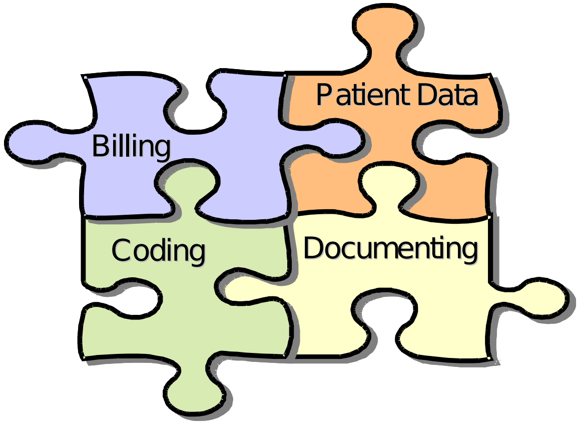
CORE COMPETENCIES

Summary

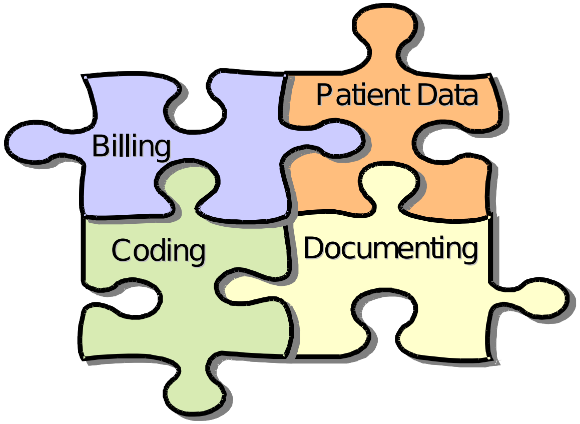

Patient Data
Billing
Coding
Documenting

- Guidelines
- Documentation
- Compliance
- Disconnect
- Solution

References

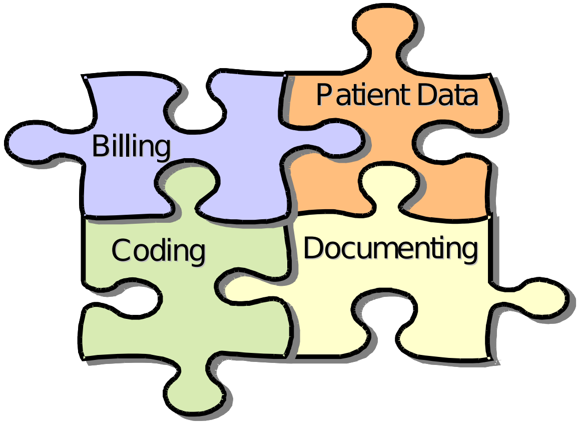

Patient Data
Billing
Coding
Documenting

- For questions regarding coding please contact your service representatives as follows:
  - Army http://www.pasba.amedd.army.mil
  - Air Force https://phsohelpdesk.brooks.af.mil 1-800-298-0230
  - Navy https://imcenter.med.navy.mil/045department/


Patient Data
Billing
Coding
Documenting

Questions?

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

How Others Use Your Data

Understanding Your Customers and Their Needs

Jeanne Yoder, Lt Col, USAF, MSC, RHIA, CPC, CCS-P, PMCC

May 2005

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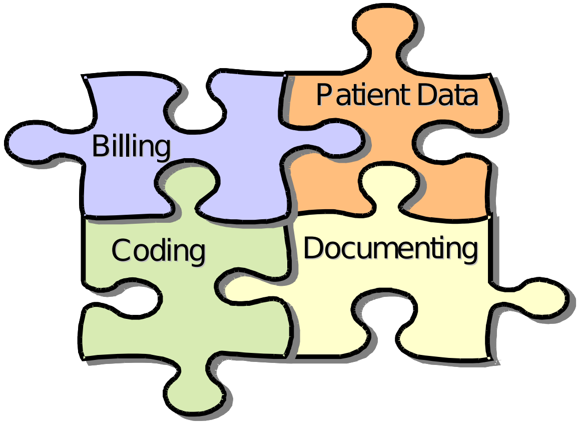
Objectives – When you leave here you should:


Patient Data
Billing
Coding
Documenting

- Be able to make yourself more valuable to your customers
- Be aware of ways your data can be used
- Be able to identify your customers
  - And your customers’ needs/wants
- Be able to tell your customers how you can help them
- Have your first steps mapped

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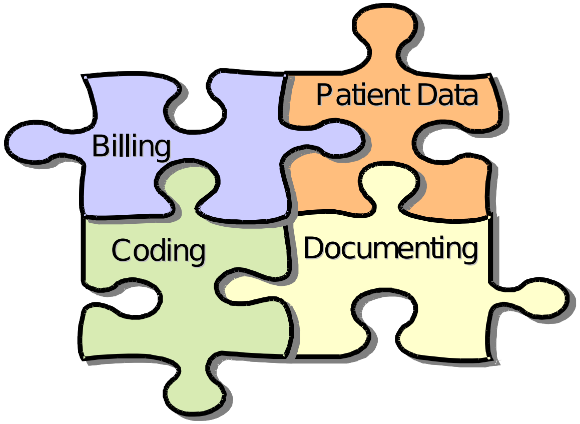
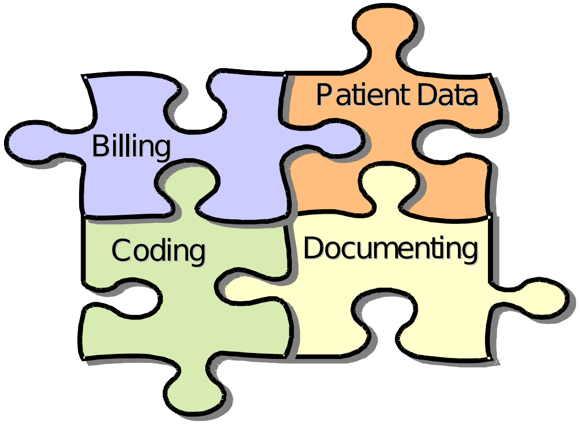
How To Make Yourself More Valuable


Billing
Patient Data
Coding
Documenting

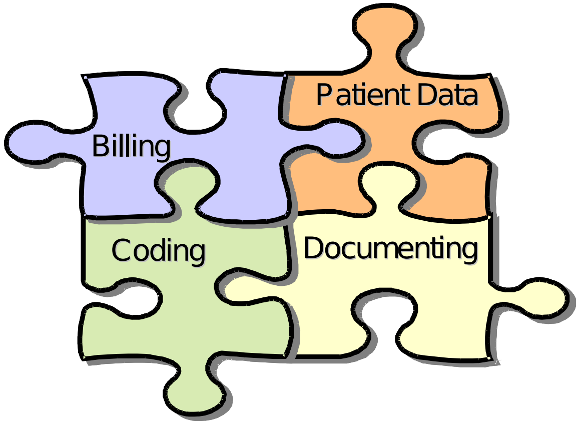
- Realize you have data your customers need
  - Even if they don’t know they are your customers
  - Even if they don’t know they need your data
- Identify the data you have
- Identify other data you could have, and the cost to collect it

What Data Do Providers Need


Patient Data
Billing
Coding
Documenting

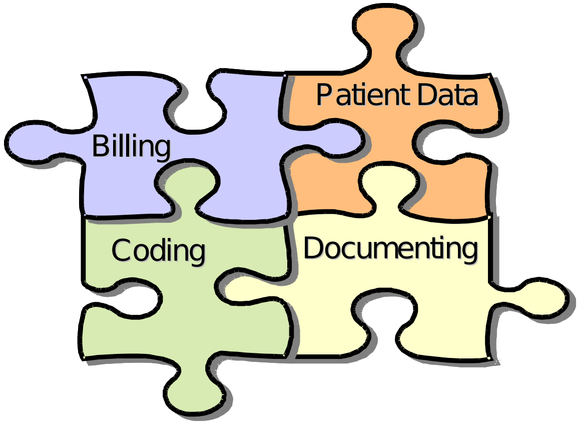
- To be able to bill
- Justify new equipment
- Justify training
- “With just one more nurse, I could…”
- Which patients are behind in preventive services?
- Which patients have not come back for follow-ups/after care?

What Data Do Providers Need



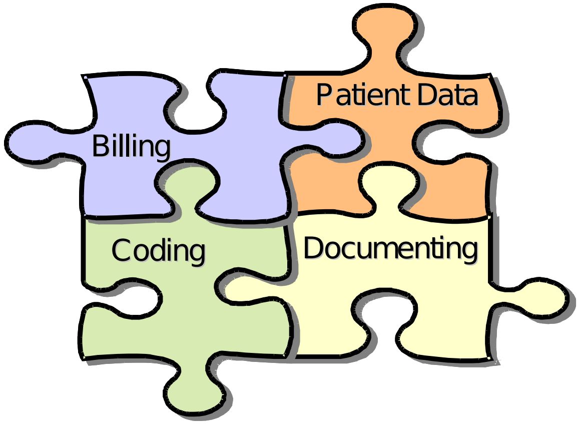
- Reportable diseases/injuries
- To “find” patients –
  - Patient was in last summer, teenager, had a fracture…
  - Baby whose umbilicus did not separate, had to use ligature; now we know this is an indicator for a more serious disease
  - Patients with ulcers
- Pull and review records for Medical Boards
- Research

What Data Do You Have?



- You know what you could collect
- You know how a provider needs to document
  - To get credit for what was done
  - To show medical necessity
  - To collect all the applicable diagnoses
  - To get the bill paid the first time (e.g., an injury needs an external cause of injury, a pregnancy needs date of last period/EDC)

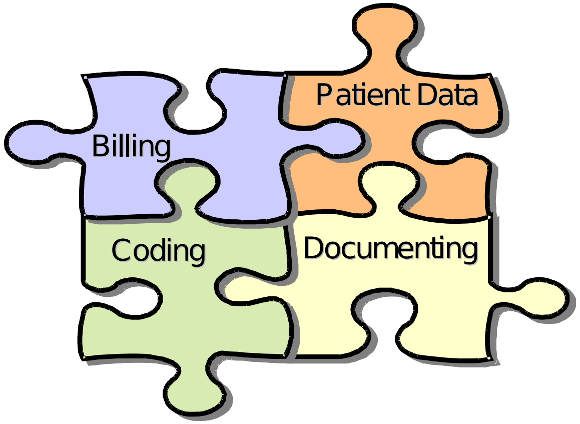
What Do Clinical Departments Need?



- Anticipate demand –
  - Acute appointments needed 2 Jan
  - Wellness/physicals needed
    - August and Dec – for school sports
    - May – for camp and summer sports programs
  - Acute appointments needed in Primary Care Clinics Monday and Friday
- Smooth out demand – identify those needing wellness so receptionist can call and make appointments for physicals on Wednesdays

CORE COMPETENCIES

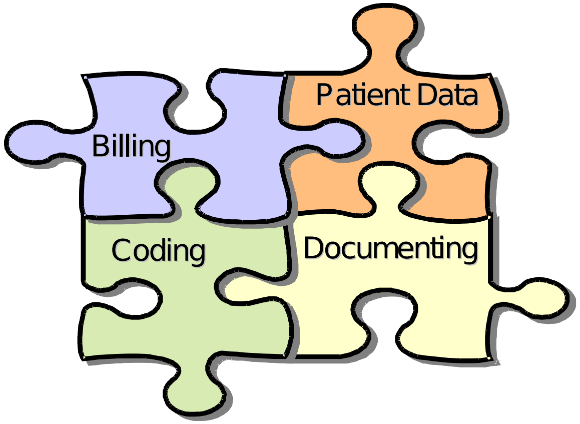
What Do Clinical Departments Need?



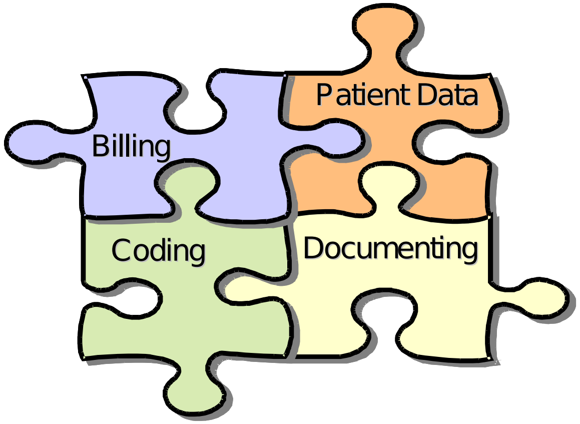
- HEDIS
- Profiling
- Relative Value Units
- Justify staff/equipment/supplies/training
- How much does it cost to provide the service?
- What are covered services – what will the patient have to pay for?
- Data to justify research to obtain grants – if the initial/control data is not available, no solid justification

CORE COMPETENCIES

What Do Clinical Departments Need? HEDIS



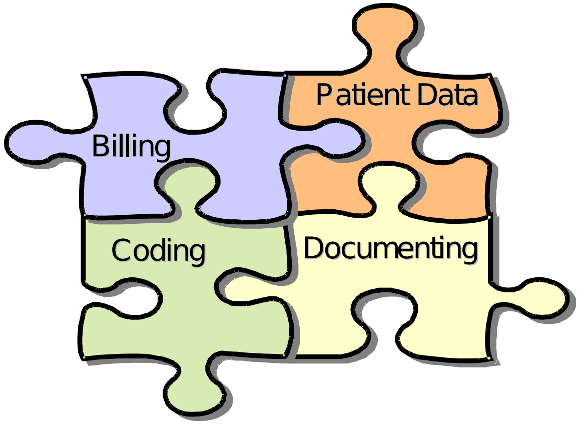
- Health Plan Employer Data and Information Set
- National Committee for Quality Assurance
- http://www.ncqa.org/Programs/HEDIS/
- Performance measures for health issues
- Diabetes, heart disease, smoking, cancer…
- S3000 – Diabetic indicator; retinal eye exam, dilated, bilateral



HEDIS Examples

- Specific Guidelines for Effectiveness of Care Measures
- Childhood Immunization Status
- Adolescent Immunization Status
- Appropriate Treatment for Children With Upper Respiratory Infection *(First-Year Measure)*
- Appropriate Testing for Children With Pharyngitis *(First-Year Measure)*
- Colorectal Cancer Screening *(First-Year Measures)*
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Osteoporosis Management in Women Who Had a Fracture *(First-Year Measure)*
- Controlling High Blood Pressure
- Beta-Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Event
- Comprehensive Diabetes Care
- Use of Appropriate Medications for People With Asthma
- Follow-Up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Medical Assistance With Smoking Cessation
- Flu Shots for Adults Ages 50–64
- Flu Shots for Older Adults
- Pneumonia Vaccination Status for Older Adults
- The Medicare Health Outcomes Survey

CORE COMPETENCIES

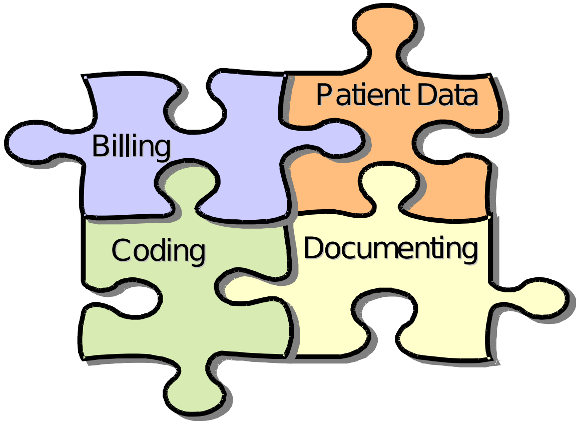


HEDIS Examples

- Adults’ Access to Preventive/Ambulatory Health Services
- Children’s and Adolescents’ Access to Primary Care Practitioners
- Prenatal and Postpartum Care
- Annual Dental Visit
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  (First-Year Measure)
- Claims Timeliness
- Call Answer Timeliness
- Call Abandonment

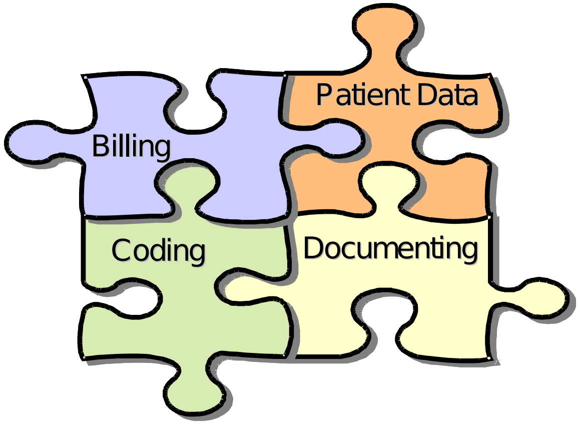
CORE COMPETENCIES

HEDIS Examples



- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits
- Frequency of Selected Procedures
- Inpatient Utilization—General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization—Nonacute Care

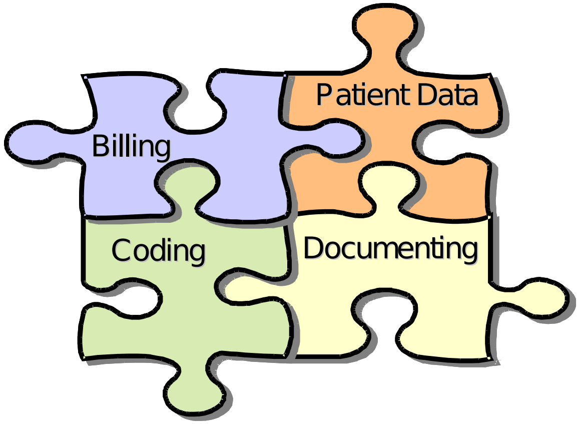
HEDIS Examples



- Discharges and Average Length of Stay—Maternity Care
- Cesarean Section Rate
- Vaginal Birth After Cesarean Section Rate (VBAC Rate)
- Births and Average Length of Stay, Newborns
- Mental Health Utilization—Inpatient Discharges and Average Length of Stay
- Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay
- Chemical Dependency Utilization—Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services
- Identification of Alcohol and Other Drug Services *(First-Year Measure)*
- Outpatient Drug Utilization

CORE COMPETENCIES

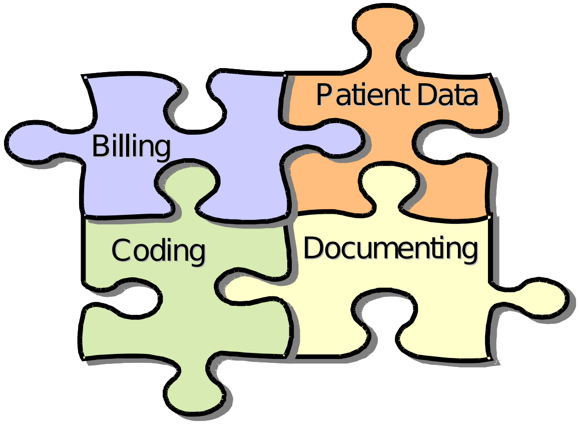
What Do Clinical Departments Need? Diagnosis Profiling



- Pick a diagnosis, e.g., sinusitis
- Determine standards of care for diagnosis
- Pull all data for encounters with diagnosis
- Compare coded services, prescriptions with expected care
- Determine differences, have physician review
- Brief staff on findings

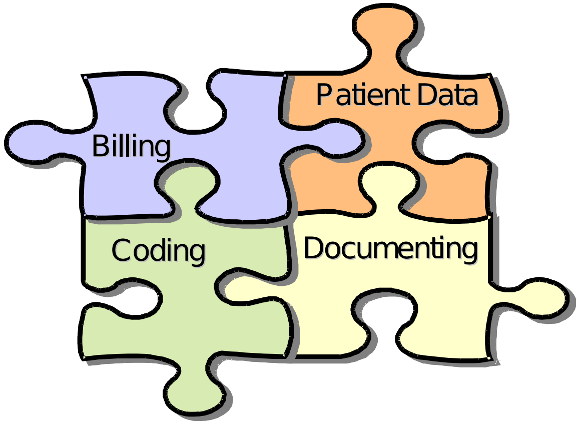
CORE COMPETENCIES

What Do Clinical Departments Need? Provider Profiling



- Look for
  - Bell shaped curves to 992xx
  - Mix of wellness/physicals in primary care
  - Common procedures
  - 99024 in surgical specialties
  - Mix of consults in specialties
  - Tobacco use disorder in about 30% of your adult population, it impacts many disease processes as it is systemic
    - Also a good way to identify training needs
  - V-codes
  - E-codes

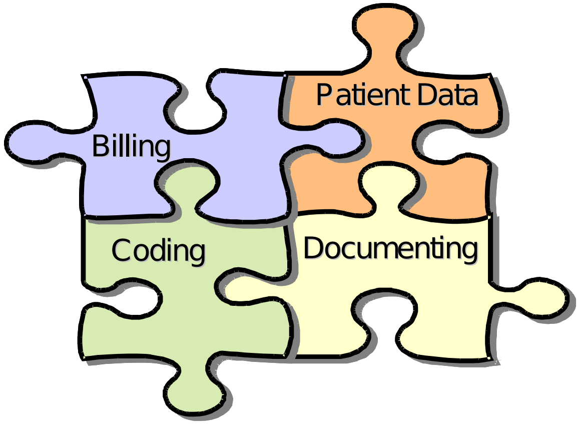
Relative Value Units



- http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp
- Download the **CY 2005** in .ZIP (**requires UNZip** software)
- RVU05A_R.zip 1.6MB zip file -- Requires UNZIP software -- 2005 revision file -- The revision includes the changes identified in the forthcoming CR3595.
- Teach your practice managers that workload can be separated from cost

C O R E C O M P E T E N C I E S

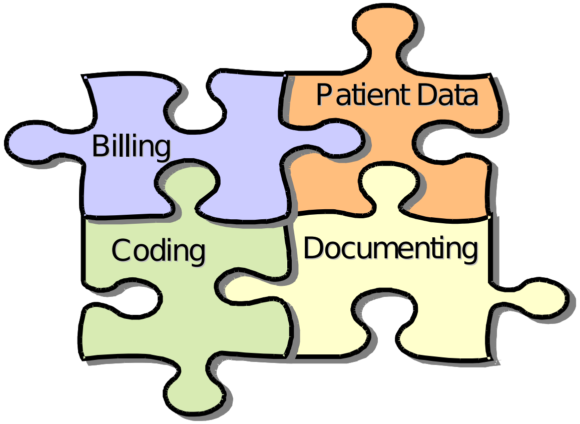
What Do Ancillary Departments Need?


Patient Data
Billing
Coding
Documenting

- They need coding expertise too
- Find out what they are collecting
- Show them how they can collect data to make medical/business decisions

CORE COMPETENCIES

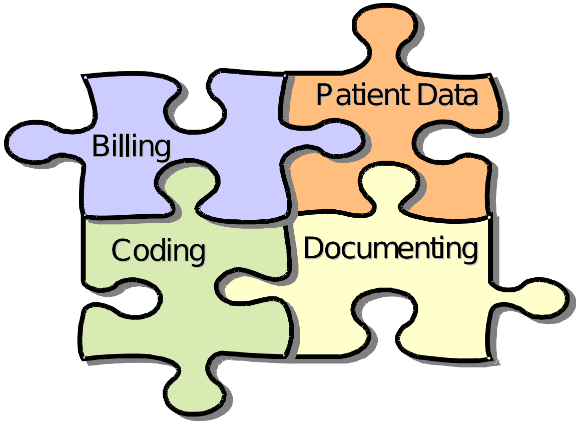
What Does Billing Need?



- Clean data, no National Correct Coding Initiative Edits
- Medical necessity documented and coded
- All billable procedures and supplies
- Help to understand denials based on coding - to figure out the issue and have a recommendation if they have to speak with the provider

CORE COMPETENCIES

What Does Marketing Need?


Patient Data
Billing
Coding
Documenting

- HEDIS – show your plan is better than others in a specific facet of prevention
- Common diseases – know what your population has, then publish articles on how self care and how your practice excels in treating these patients
- Numbers of specific procedures

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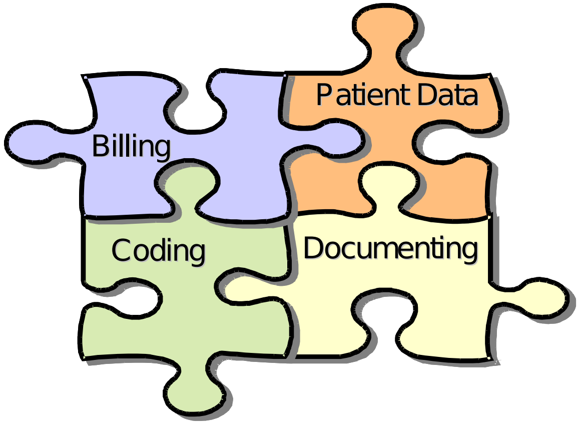
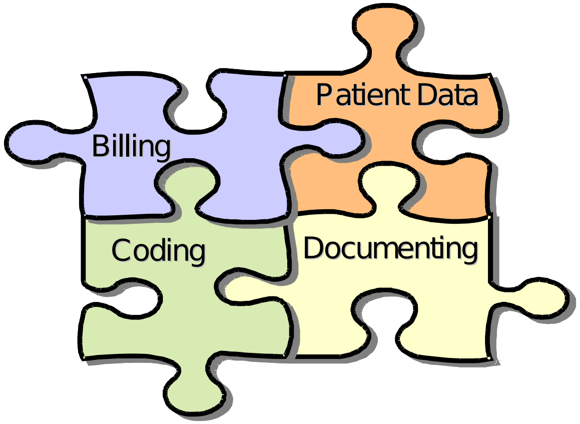
What Does Quality Assurance Need?


Patient Data
Billing
Coding
Documenting

- Clean data
  - No under or over diagnosing
  - No under or over E&M
  - No under or over procedures
  - Cosmetic is cosmetic, not medical necessity
- Serious diagnosis on the bill but not on the consult
- E&M significantly higher (2 levels or more) than documentation

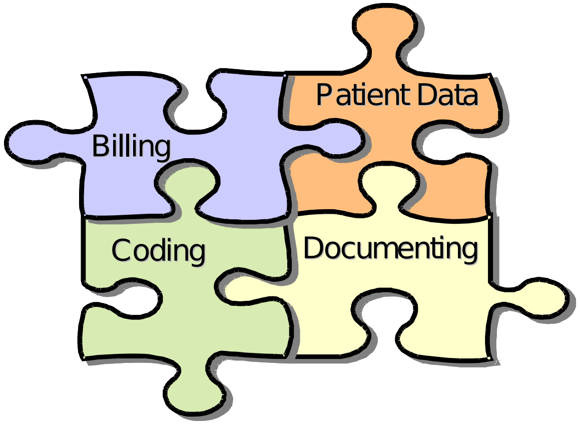

Patient Data
Billing
Coding
Documenting

Who Are Your Customers? External

- Patients

CORE COMPETENCIES

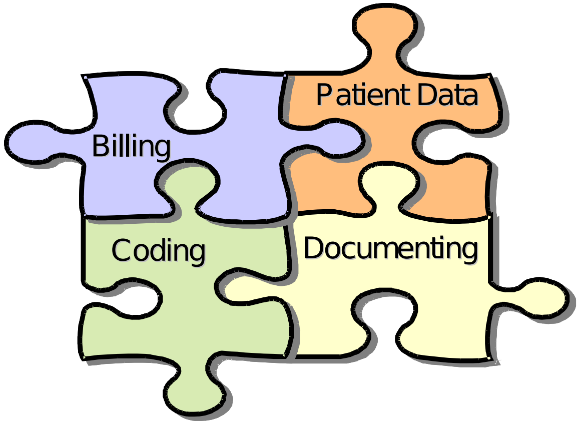
What Do Patients Need?



- Incorrect coding on bills to insurance companies can permanently harm a patient
  - Causes future insurance companies to over estimate your medical baggage
  - Causes patient unjustified higher premiums
  - May prevent patient from getting life insurance or health insurance
  - May saddle a patient with a “pre-existing condition” when there wasn’t one
- School admission forms
  - Childhood illnesses or vaccinations or titers
- Insurance applications
- Dates of treatment/surgeries/diagnoses

CORE COMPETENCIES

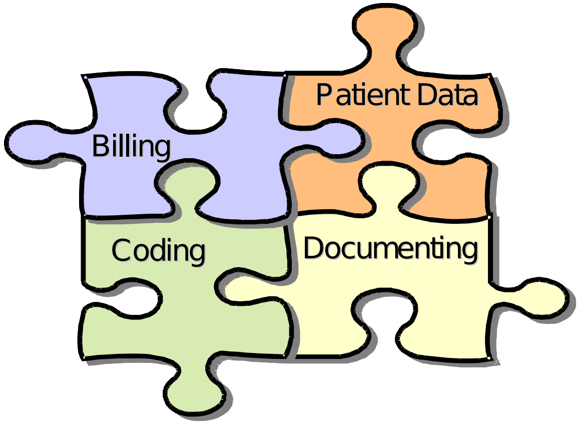
What Do The Centers for Disease Control Need? Local Health Department Need?


Billing
Patient Data
Coding
Documenting

- Reportable Diseases
  - http://www.cdc.gov/epo/dphsi/phs/infdis2005.htm
- Excellent source for training information, gives definitive diagnosis data

CORE COMPETENCIES

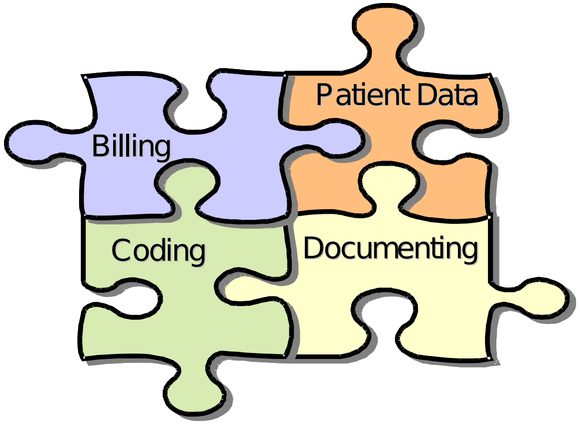
What Does OSHA Need?


Billing
Patient Data
Coding
Documenting

- Work related
  - Hearing baselines
  - Respirator fit testing
  - Shop visits

CORE COMPETENCIES

What Do The Police/Social Services Need?


Patient Data
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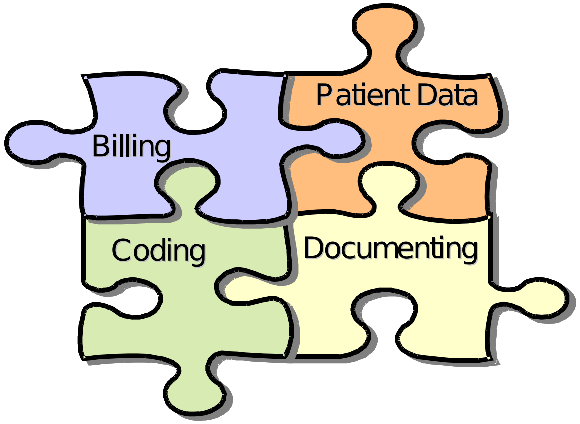
Documenting

- Reportable injuries
  - Knife
  - Gunshot
  - Abuse
  - Neglect

- Some issues are legal, not medical
  - Blood Alcohol Tests
  - Rape Protocols

CORE COMPETENCIES

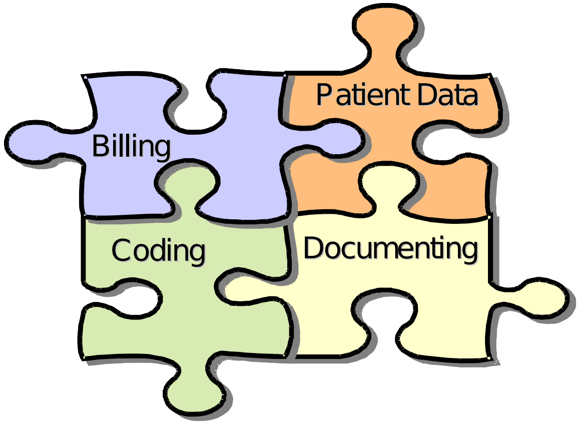
What do Insurance Companies Need?



- To be able to determine “risk level” of patient
- To be able to determine if a customer will pay for the benefit and how much does the benefit usually cost different groups of patients
- Was it work related
- Early Warning Codes
- Risk Factors
- Life Insurance Companies – Death Certificates

CORE COMPETENCIES

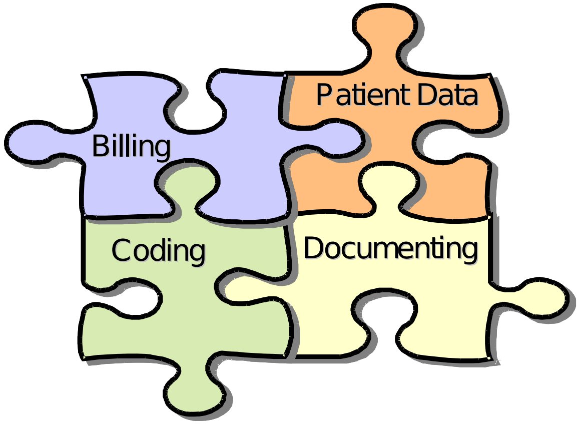
What Do Researchers/ Epidemiologists Need?



- Reliable data
  - Code what is documented
  - Bills with more serious illnesses than indicated in the documentation, Researcher pulls records based on insurance billing data, finds nothing
  - Bills with only symptoms, but not diagnoses (don’t want to code a 290-319 to avoid “stigma”), researchers can’t find patients

CORE COMPETENCIES

Epidemiology/Research


Patient Data
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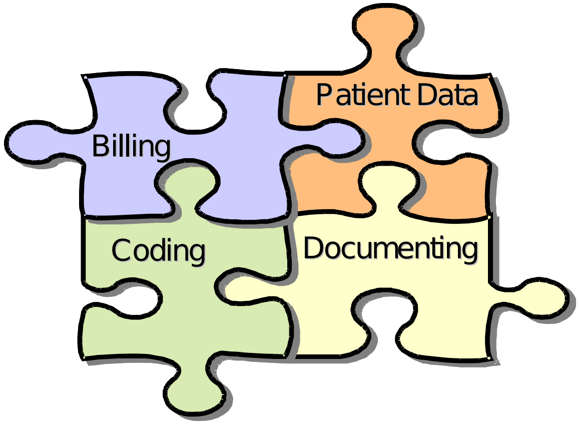
Documenting

- Smoking
- Agent Orange
- Gulf War Syndrome
- Adulterated Drugs
- Mold: No Link Found to Serious Health Disorders
- Cancer: Study Suggests Chernobyl Affected Sweden

CORE COMPETENCIES

Epidemiology/Research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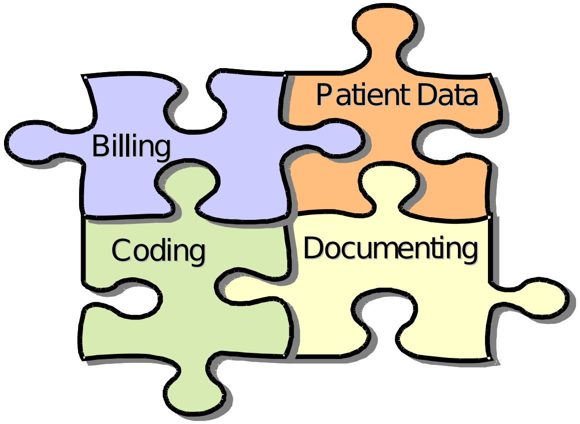
- Work place safety – E-codes
- Human Genome
- Heating food in plastic with microwaves
- Mercury in tooth fillings

New Drugs/Procedures


Billing
Patient Data
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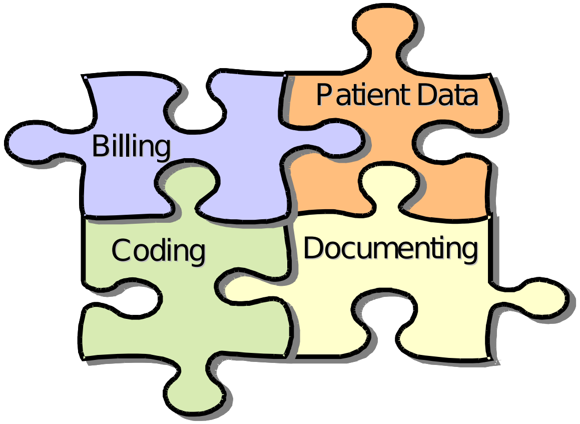
Documenting

- Orphan Drugs
- Gene Therapy
- Finding patients for pre-FDA approval testing

CORE COMPETENCIES

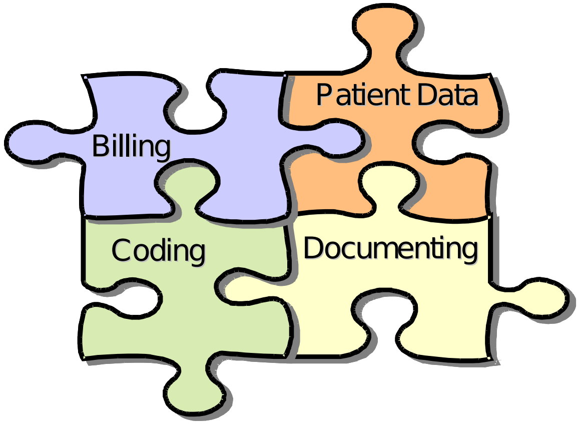
How To Collect Procedures Without CPT/HCPCS



- Uniquely cosmetic procedures
  - Laser tattoo removal
  - Electrically removing hair
- Administrative procedures
  - Filling out an insurance application
  - Completing an application for a handicapped sticker
- OSHA/Other Regulatory – e.g., newborn hearing assessment, was it done?

C O R E C O M P E T E N C I E S

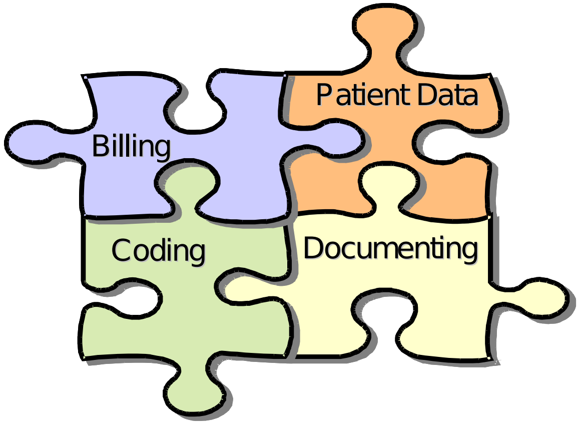
HIPAA – Health Insurance Portability and Authorization Act



- In regards to data
  - HIPAA impacts electronic data sets, such as those used for billing, obtaining pre-certifications, and coordinating consults
  - Lots of things are not impacted by HIPAA
    - Cosmetic procedures – you will not be billing the insurance companies (which would involve a HIPAA transaction), you will be billing the patient directly
    - Tracking patients who decline paps/ mammograms/other screening/vaccinations

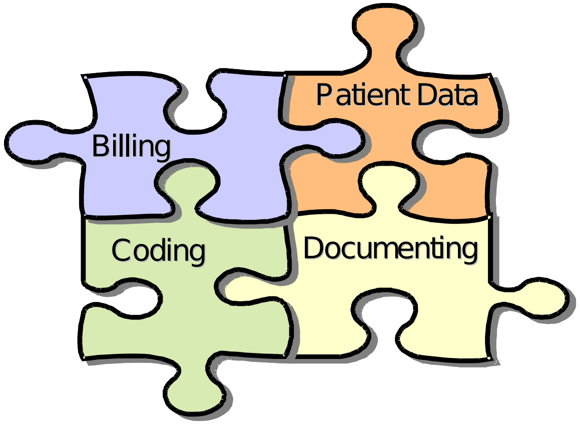
CORE COMPETENCIES

Make Yourself More Valuable



- Once you think you have all your providers documenting well and that your practice's coding is excellent
  - Offer to audit another practice if their coder/auditor will audit yours – you both learn new things
  - Learn about HEDIS, think of what you collect, compare your practice to others, identify what would be needed to have your practice excel
  - Learn about Relative Value Units, teach others, apply
  - Profile your practice on various common diagnoses

Be Sensitive


Patient Data
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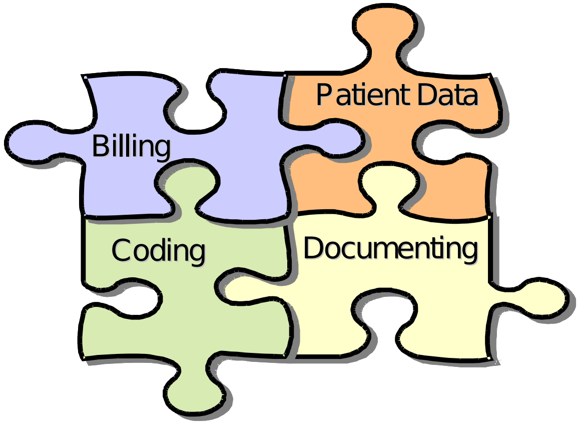
- Provider Profiling and other nasty terms
  - Data has been used by some to beat up providers
  - Compare to like populations
- Too much data, not enough information
- Explain how it can help them or their patients
  - Justify training programs

Mapping Your First Steps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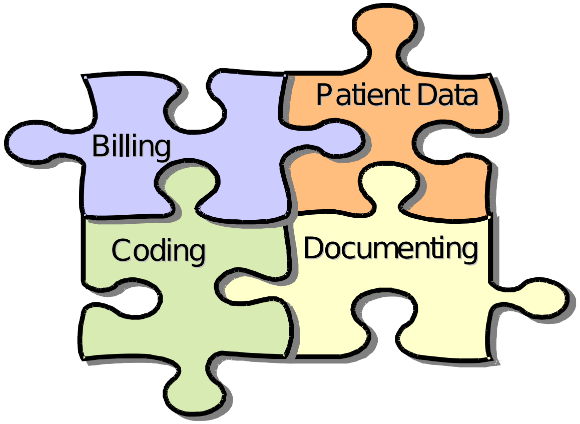
- Identify ALL your data users
- What are you already collecting?
- Is there someone who could use the data if they knew you had it?
- Go tell them

CORE COMPETENCIES

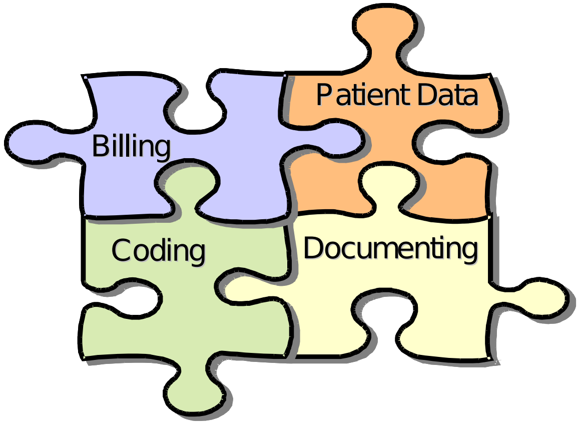
And Your Next Step



- Ask others if there is something they would like to know?
- Is there someway you could collect it?
- Will your computer system accept it?
- Is the time to collect it worth the information?
- If you collect it, will that impact some other system negatively? Will it impact billing? Staffing?

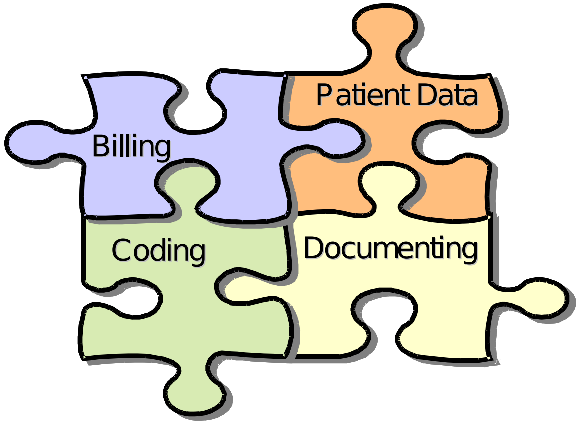
CORE COMPETENCIES

Objectives – You should now have ideas on:



- Making yourself more valuable to your customers
- Ways your data can be used
- Identifying your customers and your customers’ needs/wants
- Going to your boss with ideas on new ways the data can be used
- Your first steps to help others mine the valuable data they have

Questions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